Hedical

A Monthly Journal of Medicine, Surgery and the Collateral Sciences Published by THE MEDICAL TIMES COMPANY at 95 Nassau Street

VOL. XLIX., No. 4

NEW YORK, APRIL, 1921

Twenty Cents a Copy Two Dollars a Year

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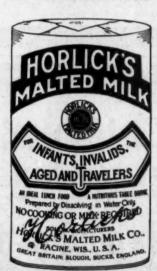
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General Scientific

SILVER-SALVARSAN* A Preliminary Report

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Silver-salvarsan is the result of the activation and biological reinforcement of salvarsan with silver. It contains about 20 per cent. of arsenic and 14 per cent. of silver and is known chemically as the disodium salt of silver-diamino-dihydroxy-arsenobenzene.

Silver-salvarsan sodium is made by allowing silver salts to react upon m-diamino-p-dihydroxy-arseno-benzene-dihydrochloride, and by converting the resulting product into the disodium salt. Silver-salvarsan is a brownish black powder, easily soluble in cold water, with an alkaline reaction.

This new arsphenamine product has been clinically employed in Europe for something over two years and more than one million doses have been administered.

Silver-Salvarsan in the United States.

Silver-salvarsan was first produced in this country by the H. A. Metz Laboratories in the summer of 1920, and clinical studies with the product began in October, 1920. The first report on silver-salvarsan in this country was made before the New York Academy of Medicine, Section on Dermatology and Syphilis, Dec. 7, 1920, by Dr. M. B. Parounagian, Director of the Department of Syphilology at Bellevue Hospital (Arch. Derm. & Syph, March 1921), and a couple of days later before the All-American Conference on Venereal Diseases in Washington by Dr. John A. Fordyce, Professor of Dermatology and Syphilology in the College of Physicians and Surgeons of Columbia University.

In such New York institutions as the Vanderbilt Clinic and City Hospital, services of Dr. Fordyce; Rellevue Hospital, services of Dr. Fordyce;

In such New York institutions as the Vanderbilt Clinic and City Hospital, services of Dr. Fordyce; Bellevue Hospital, service of Dr. Parounagian; New York Skin & Cancer Hospital, service of Dr. Dudley D. Stetson; Volunteer Hospital, service of the writer, and in other hospitals, dispensaries and private offices

over 4,900 injections of silver-salvarsan had been given up to March 1, 1921. The writer has taken part in or been present at the administration of probably one-half of this number, through the courtesy of Drs. Fordyce, Parounagian and Stetson.

Features of Silver-Salvarsan.

As a result of these observations these opinions of silver-salvarsan have been formed:

- I. It is better borne than any of the other arsphenamines, only seven reactions have come to our attention. Of these, four, two men and two women, were delayed between five to six hours after injection and consisted of chills and fever and did not occur again in the same patient. One, a woman, was angioneurotic in type and very mild; another, a woman, complained of headache and dizziness on leaving the table, a condition that speedily disappeared. The last, a man, who had not evacuated his bowels on the day of injection and had partaken of a heavy meal, showed fairly severe nitritoid symptoms after a concentrated injection in distilled water.
- 2. The clinical symptoms, particularly chancres and mucous patches and condylomata, disappeared with great rapidity in most cases. Action on other cutaneous lesions was practically the same as that following arsphenamine and neoarsphenamine.
- The product is almost immediately soluble in water, needs no alkalinization and the quantity of the drug employed is very small.
- The chemo-therapeutic factor is large, while the burden of elimination is small on account of high efficiency.
- 5. The serological results, as far as observed, are easily comparable with the other arsphenamines, both in primary and secondary lues. In tertiary types it may be preferable to utilize mercury in combination.
- 6. No cases of albuminuria were seen.
- 7. Many patients were able to return to their

^{*} From the Department of Syphilology, Volunteer Hospital.

places of business from the hospital or office, although this procedure is not to be recom-

mended as routine practice.

8. Silver-salvarsan's use in the intraspinous treatment of neurosyphilis, while limited, has been eminently satisfactory and it would appear to offer a therapeutic agent of unusual

The Employment of Mercury.

A factor which will appeal to many syphilologists is that mercury is not recommended for use in combination with silver-salvarsan, at least in the early stages. The progenitors state that "if silver-salvarsan is well tolerated by the patient, the use of mercury is not indicated in lues in the primary and secondary stages. Iodin preparations may be given simultaneously with silver-salvarsan if desired. Except for local treatment, mercury should only be resorted to after the salvarsan treatment has been stopped and in cases where salvarsan treatment generally is not tolerated, or in patients who are hypersensitive to arsenic. This also applies to patients in whom the Wassermann reaction does not show negative results

after from 10 to 14 injections."

The author has had a limited personal experience with the combination of mercury and silver-salvarsan. The clinical and serological results in this series have followed the employment of silver-salvarsan

alone.

At Volunteer Hospital, my associates, Drs. Gauvain, Lavalle and Helmick, have different series of cases under observation in which various combinations of silver-salvarsan and other drugs are being utilized and the results will be the basis for further report.

Foreign observers are divided upon the advisability of utilizing mercury with the silver arsphenamine.

Gennerich (Deut. med. Woch., No. 45, 1918) does not believe in the use of mercury. He positively states that he obtains negative Wassermanns quicker with silver-salvarsan alone than with other salvarsans, even when mercury is employed. He is only in favor of mercury when a third course is necessary.

Another careful investigator, Galewsky (Munch, med. Woch., No. 5, 1920) reports upon two years' experience with silver-salvarsan and says he prefers it alone rather than in combination with mercury. He is of the opinion that in the drug we have the best anti-luetic yet brought out and find that it has less after effect than any he has

used.

There are, however, some men who prefer to com-

bine mercury with silver-salvarsan.

Major C. M. Walson, U. S. Army (Am. Jour. Med. Sci., March, 1921) presents an exhaustive study on "Silver-Salvarsan in the Treatment of Syphilis," based on 800 patients treated with over 6,000 injections of silver-salvarsan. Practically all patients had mercury in the form of gray oil. His advice is to 'give mercury with silver-salvarsan until it has been definitely proved that mercury is unnecessary.

The writer is in entire accord with H. N. Cole (J. A. M. A.) regarding the inadvisability of utilizing gray oil as a synergist to arsphenamine, but Walson's findings indicate that his treatment is uniformly

successful.

This success may, however, be due to the action of the silver-salvarsan which he says (ibid) "is the strongest spirocheticide, as well as being the least toxic of all arsenobenzol preparations, according to results obtained from animal experimentation, that

has yet been introduced, and nothing has so far developed in its clinical application to contradict these observations.'

Dosage.

The dosage of the drug is of interest and it is again one of the factors of advantage.

The maximum dose is 0.3 gram, as set by many of the foreign users, or 0.25 gram, as determined by Kolle, of Frankfort, the successor to Ehrlich, who was working on silver-salvarsan at the time of his death.

This dosage is markedly in contradistinction to the maximum doses of arsphenamine and neoarsphena-

mine, 0.6 and 0.9 gram respectively.

Our practice has been to administer to men and women alike 0.1 gram at the first treatment. Four days later the patient receives 0.15 to 0.2 gram, according to sex and physical condition. The dosage is then increased so that men receive a maximum of 0.25 gram for the third injection and women 0.2 gram. In some instances we have given strong men 0.3 gram and women, who could apparently handle a larger amount, 0.25 gram, and in no instance has the slightest difficulty ensued. We are of the opinion that the larger dosage can be safely employed when occasion demands.

Amount of Silver-Salvarsan Necessary.

In treating syphilis it has long been our opinion that we undertreat our cases with arsenicals. employing salvarsan in the ordinary primary or secondary case, we now insist on not less than 20 injections the first year, given in three courses of ten, six and four respectively, with an abundance of bichloridol, I grain, two or three times a week intramuscularly.

A month should elapse between courses.

When neosalvarsan is the drug of choice, 24 injections, in three courses of twelve, six and six respec-

tively is our routine.

It is a natural feeling, therefore, that silver-salvarsan should be used along the same lines. There has not yet been sufficient time and opportunity to enable us to perfect a plan which may be regarded in the light of experience as a standard for our own service, but at present we recommend that patients take three courses of twelve, ten and eight injections, with intervals of one month.

This plan will be subject to necessary modification.

Concentration.

The manufacturers recommend that the contents of an ampule be sprinkled on the surface of 5 c. c. of sterile, double distilled water. It dissolves rapidly and completely. Then sufficient room-temperature (68-71°F) 0.4 per cent. (not physiological) sterile saline solution is added to make the dilution 20 c. c. per decigram. Thus a dose of 0.2 gram would be given in 5 c. c. distilled water and 35 c. c. of 0.4 per cent. saline, or 40 c. c. of fluid. This dilution has been used very largely in this country by the clinical investigators who are studying the drug. Indeed investigators who are studying the drug. Indeed such a careful observer as Parounagian, of Bellevue, uses 30 c. c. per decigram and he reports that greater concentrations are unsatisfactory to him.

On the other hand, a few physicians in the United

States and very many in Europe utilize more con-

centrated dilutions with satisfaction.

Major Walson (ibid) uses 20 c. c. of freshly distilled water, with no saline, for any sized dose and injects by means of a glass syringe. Kolle (Deut. med. Woch., No. 2, 1920) has employed as little as 10 c. c. of distilled water to each decigram of the drug.

At Volunteer Hospital we are attempting to pertect a technic which will prove satisfactory to our necessities. We commenced by dissolving the silversalvarsan in 5 c. c. of distilled water and adding 45 c. c. of 0.4 per cent. saline, making 50 c. c. of fluid to the decigram. The injection was made with the salvarsan gravity apparatus. We then dropped to 40 c. c. of fluid per decigram and later to 30 c. c. With fear and trembling the fluid was reduced to 20 c. c. per decigram and of late we have experimented with 10 c. c. of distilled water to the decigram, using no saline, and administered by means of a glass syringe.

It is too early to state results with the very concentrated solution, other than that the patients appear to bear the concentration quite well, and only one reaction has been observed. We are not prepared to advise this method as yet, however.

Slow Injection an Absolute Essential.

It is absolutely essential that three minutes by the watch be employed in introducing a highly concentrated solution into the circulatory system.

Grave results are likely to follow a more rapid injection and in the fear that too much speed will produce serious consequences we do not recommend the general employment of this concentration.

Technic of Administration.

Silver-salvarsan ampules should be immersed in 95 per cent. alcohol for 15 minutes. If no crack in the glass develops the ampule is opened and the contents sprinkled on the surface of the water as hereinbefore described.

As soon as the solution is ready it should be filtered through previously moistened sterile cotton or geuze. The brownish black solution is then put into the gravity apparatus or, if a sufficiently concentrated solution is to be used, drawn into the syringe.

As silver-salvarsan is believed to have an irritating effect upon the tissues, the operator should be certain that his needle is properly introduced. When the backward flow indicates free entrance into the vein, the tubing or the syringe is attached to the needle and administration is undertaken very slowly. Upon the withdrawal of the needle the site of the injection should immediately be covered with sterile gauze and manual pressure exerted. When bleeding has stopped the area should be covered with collodion.

Effect on the Wassermann Reaction.

Time has not permitted us to report on a considerable number of cases treated with silver-salvarsan. The work done on a great many of these cases, observed by us, will be given to the profession by the other investigators.

We have had 14 cases which have completed at least one course. Of these 10 were changed from positive to negative. In two of the others there was a reduction from 4 plus to 2 plus and in two others there was no change in the reaction. Three cases were tertiary and the others, primary and secondary. One of the tertiaries changed to negative and the other two remained positive and are receiving further treatment.

It will be necessary to watch a large number of cases before giving a definite opinion which will be likely to stand the test of time. If this small number is any criterion, silver-salvarsan has a marked effect on the Wassermann reaction.

The Possibility of Argyria.

Major Walson (ibid) says he has "not been able to find any case of argyria reported in the literature, as the result of silver-salvarsan treatment." He further adds that none of his cases have developed any such manifestations.

Our investigation of the so-called argyria case noted in J. A. M. A. abstracted from Derm. Zeit., has shown that the report was not based upon fact. The case was treated by a "naturopath" and the physician who made the report stat-d he had never seen the patient, although he "nad asked the patient to call" upon him.

If three courses of silver-salvarsan, as specified above, be given, the total amount of silver-salvarsan administered would be 7.30 grams, which would contain 1.02 grams of metallic silver and 14.6 grams of arsenic, as compared with 37.8 grams of arsenic in the arsphenamine treatment when 20 injections of 0.6 gram dosage are administered. In addition we would administer 3.0 grams of bichlorid of mercury, by employing from two to three one-grain bichloridol

collapsules weekly.

The situation regarding silver is so graphically described by Dr. Torald Solmann in his Manual of Pharmacology, page 780, that we are quoting from his book herewith:

"General Statement.

"The inorganic silver salts, especially the nitrate, are used to produce astringent, caustic and antiseptic effects. They form resistant precipitates with proteins, so that their local action is easily controlled. The toxicity for higher animals is very low, and the antiseptic efficiency is high. In the presence of the tissues, silver surpasses mercury, since the protein compounds of silver are also antiseptic. These may be used directly when antiseptic action without irritation is desired.

"Silver is not absorbed in sufficient quantity from the alimentary canal to produce systemic actions. Because of its precipitation by proteins and chlorid, even large doses of silver nitrate rarely produce serious poisoning. Long-continued use results in blackish discoloration of the skin (argyrism) by the deposition of silver particles, probably organic. Traces must therefore be absorbed.

"Argyrism.

"This develops gradually after prolonged internal or external use of silver when the total dose has reached 15-30 grams. Since silver is now rarely used in this way the condition is infrequent. It has been produced by the application of silver-containing hair dyes. Argyrism consists in a bluish-black discoloration of the skin, especially where exposed to light; and of internal organs and mucous membranes (Frommann, 1857; Riemer, 1876). The black granules do not consist of metallic silver, for they are easily soluble in KCN, and difficultly in concentrated nitric acid. In the skin, they are situated in the connective tissue of the corium, and remain indefinitely. No silver can be demonstrated in the urine. The argyrism does not give rise to other symptoms. In animals, silver deposition has also been produced in internal organs, but not in the skin."

In view of the fact that three courses would give practically only a fractional amount of the silver which Solmann says is the minimum amount to cause argyria, it is easy to be seen that there is very little likelihood of this condition arising.

16 Fifth avenue.

THE PERIODIC PHYSICAL EXAMINATION AND THE MINOR MALADIES,

ARTHUR F. KRAETZER, M.D., ASSISTANT ATTENDING PHYSICIAN, OUT-PATIENT BEPARTMENT; ASSISTANT ATTENDING DERMATQLOGIST, UNIVERSITY AND BELLEVUE MEDICAL COLLEGE,

New York.

There can be no question regarding the necessity of the periodic physical examination. No company can exist without regularly taking account of stock. An engineer who fails to inspect his machine at definite intervals, who waits for the crash to come and then tries to find out what the matter is, is not to be trusted with responsibility.

Equally improvident is the man who fails to undergo a more or less frequent investigation by an expert physician.

Far more careless is the practitioner who adopts the all too frequent attitude of laissez-faire, who is too inert intellectually to seek and discover the beginnings of disease, and who, when disaster finally comes, when diagnosis can be beautifully made and pathology most elaborately demonstrated, reassures himself for his helplessness by the unquestionable fact that the condition is hopeless. Hopeless now, yes. But what about five years ago? Too often the excuse is given to a bereaved family, that "nothing can be done," that it is the essentially fatal nature of the disease and not the lack of skill or knowledge on the part of the physician that leads to the inevitable outcome. But eventually the people, whose hygienic trustees we are, will demand that we prevent chronic disease and not feel that we have done our full duty by merely pronouncing sentence.

We share that unfortunate preference of all human minds for clear-cut intellectual concepts. We speak of a well-rounded clinical entity as a "beautiful case," We are suspicious of all that is vague and ill-defined as unscientific. But the beginnings of everything are vague and ill-defined. An eminent physiological chemist once said to me, "The trouble with you doctors is that you don't know what constitutes the normal, and you don't know anything about the origin of chronic disease. In all the centuries that diabetes has been recognized, no one has ever described a beginning case."

The first step in the correction of all this is the making and recording of the periodic physical examination. This shall comprise:

A. History.
B. Physical examination.

C. Laboratory work.

A. The history must include family history, (with especial reference to diabetes, obesity, cancer and all other chronic manifestations), past history (infectious diseases, injuries, operations, residence in foreign countries, former illnesses of all kinds), present history (analysis of symptoms, personal habits regarding food, sleep, exercise, alcohol, tobacco, tea and coffee). In women the menstrual history is of the greatest importance, especially the age of onset, frequency, regularity, and premenstrual symptoms.

B. The physical examination proper must take up systematically every region and system of the body. The following schema is simple and easy:

1. General apearance-mentality, carriage, weight, height, gait.

2. Mouth and pharynx-lips, pallor.

Tongue—Symmetry, coating, moisture, tremor, indentations by teeth, condition of base, (hypertrophied lingual tonsils, smooth atrophy of syphilis, etc.).

Fauces-Scars, congestion, faucial tonsils.

Naso-Pharynx-Mucosa, septal deformity, condition of turbinates, discharge, adenoids, transillumination of accessory sinuses.

Gums—Pyorrhoea.
Teeth—Caries, gold crowns, foul bridge work.
3. Eyes—Congestion of tarsal conjunctivae, bulbarconjunctiva, iritis, reaction to light and accommodation, nystagmus, strabismus, ptosis or exophthalmos, examination of eye-grounds.

4. Ears—Condition of external meatus and tympanic

membrane; tophi.

5. Heart—Inspection and palpation of impulse, position of apex, area of cardiac dullness, rate, rythm, character of sounds, murmurs, response to exercise.

6. Vascular-Inspection and palpation of superficial arteries, blood pressure, ophthalmoscopic examination of retinal vessels, distended veins.

7. Lungs-Formal examination.

Abdomen-Areas of tenderness and muscular spasm, palpable organs or masses. Rectal examination should invariably be made.

9. Lymphatic-Examination of the superficial node

groups.

10. Skin—Pale, sallow, subcyanotic, thin, thick, dry, moist, hairy development, pimples, acne, eruptions, reaction to stroking, livedo, acro-asphyxia, scars.

11. Muscular-Development, tone, symmetry, ten-

derness, crepitation, hernia.

12. Bones and Joints—Deformities, chronic arthro-

pathies.

13. Neurological-Pupillary, quadriceps and achilles reflexes, clonus, Babinski, Romberg. 14. Genito-Urinary-Phimosis, scars, varicocele, size

and consistency of testes, epididymitis, pros-

In young girls examination of the genitalia should not be a matter of routine but should be done only when there are presenting symptoms. In women past 30, cervix, uterus, uterine adnexa and breasts should be examined systematically whether there are presenting symptoms or not.

Laboratory Work.

1. Red cell count and hemoglobin. The latter alone is insufficient, as very often a beginning severe anemia with high color index will have a very re-

spectable hemoglobin percentage.

2. White cell count and differential count with examination of stained smear. The stained smear may reveal an unsuspected high grade anemia. Granular basophilia may lead to the discovery of unsuspected lead poisoning. An eosinophilia may give the clue to the presence of intestinal parasites. As the investigation in the late war showed the enormous prevalence of hook-worm in the Southern soldier, this is a matter to be given very serious considera-

3. The Wassermann reaction must be a matter of strictest routine. There are 110,000,000 people in this country. It is estimated that 10,000,000 of them have syphilis. In other words, every patient pre-sents a one-eleventh chance of being luetic. No business concern would overlook a 9 per cent. leak. Nor must the physician either. Nothing must induce the doctor to make an exception in this most vital matter. The patient's status in life should play no part in the negative diagnosis of syphilis. Syphilis is a function of the spirochaeta pallida, not of the patient's social position.

It is with the minor ills, however, that the periodic

physical examination must deal with special care. These are the conditions which, while not constitut-ing striking clinical entities, while not embracing the "beautiful cases" of the pathologists, nevertheless knock off a considerable percentage of a man's effi-ciency and almost certainly represent the beginnings of the serious and incurable chronic diseases. The average person, if told that he has normal heart and lungs, is not apt to get particularly excited about the information, as it is something which he has more or less taken for granted anyway. What he really wants to know is why he is "nervous," why he tires easily, why he never feels quite fit, why he suffers from flatulence and distress after eating, why he constantly "catches cold," why he suffers from symptoms, which, while not of a severity sufficient for him to consult medical advice, nevertheless considerably reduce his energy, efficiency and happiness. The purpose of this paper is to discuss the recognition and treatment of a few of these everyday ills, ills which appear with painful regularity in the typical dispensary patient, and which to a greater or less degree are shared by all of us who live under the artificial conditions of city life. The conditions are

 Constipation, associated with carbohydrate fermentation, protein putrefaction, or with both.

2. Dental sepsis.

Chronic tonsillitis.
 Chronic rhinitis, with or without disease of the

accessory sinuses.
5. Chronic fibrositis.

The average man, if asked if his bowels are regular, will generally reply with an air of pride, not to say ostentation, that they move every day. Little does he realize that he is merely paying meagre dividends, the while he retains the principle in the shape of rocky hard scybala which clog the sigmoid and rectum and apparently are too slippery and unyielding for peristalsis to get any grasp on them. Seldom has the writer performed an autopsy on an adult without finding these dessicated lumps in the lower portion of the large intestine. The agonal bowelportion of the large intestine. The agonal bowel-movement, supposedly of considerable violence, does not remove them, nor, during life, do cathartics. Presumably they slip back and forth and probably remain a considerable length of time, causing absorption, local irritation, stercoral ulcers, and in all probability, diverticulitis, to say nothing of abdominal discomfort and a constant sense of unfulfillment. The etiology of these scybala is not clear. They seem to form in the heavy eater of flesh and sweets, who leads a sedentary and more or less high-strung existence; in other words, the average city dweller. Inasmuch as this very common form of constipation occurs in the last two or three feet of the colon, it is not rational to treat it with cathartics, which besides being inefficient, insult and irritate over 25 feet of innocent and unoffending gut. The patient should take a nightly rectal injection of 4 oz. of warm olive oil, retaining it till morning. About twice a week, lying on his left side, he should take an enema of two quarts of a warm 0.5 per cent. icthyol solution. This will remove inspissated masses which cathartics have little if any effect on. Bran, agar and min-eral oil are helpful. The diet should be composed of milk, cream, cream cheese, vegetables and fruit. Sugar in all forms, meat, fish and eggs should be absolutely avoided at first, but later may be admitted to the dietary in small amounts.

Carbohydrate fermentation, which frequently accompanies constipation, is probably the result of the

inordinately high sugar consumption obtaining in this country. One hundred years ago, the annual per capita consumption of sugar was five pounds. Fifty years ago it was 25 pounds. Today it is over 90 Health cannot be maintained on such a A probably pathognomonic sign of carbohydrate fermentation is a pallid white streak on the vermilion border of the lip. The tarsal conjunctiva is markedly injected. The tongue is coated and the edges are indentated by the teeth. The latter can generally be seen only when the tongue lies in its normal position. Protruding the tongue obliterates The buccal mucosa frequently the indentations. shows an antero-posterior ridge corresponding to the line of closure of the teeth. Like the indentations of the tongue, this is caused by oedema of the mucous membrane.

The subjects of carbohydrate fermentation may be lean and ill-favored, or obese and portly. The skin may be pale, greasy, pasty or subcyanotic. There is frequently a marked tendency to acne and furuncles. Acro-asphyxia, a livid, clammy, cyanotic condition of the hands and feet is present. Livedo, a congested network enclosing pale areas of normal skin the size of a dime, is frequently present, and is most covious on the inner aspect of the fore-arm. The normal areas represent the zone of distribution of terminal cutaneous arterioles. The congested network bounding these areas represents the zone of capillary anastomosis. Eczema, pompholyx, eczmatides, rheumatoid conditions, and a tendency to colds and sore throat may exist on the basis of carbo-

hydrate fermentation.

Flatulence, dyspepsia, easy fatigue, burning of the eyes and itching of the skin are frequent concomi-Unless there is an accompanying protein putrefaction, there is an absence or very small quantity of indican in the urine. The blood-sugar is frequently increased and there may be a slight acido-The reduction of carbohydrates is the sine qua non of treatment. Sugar, potatoes, flour-containing foods (except one slice of bread with each meal) are absolutely interdicted. Animal food, meat, fish, eggs, and especially milk, cream and cream cheese, may be taken. Green vegetables, fruit (except bananas) and salads (with lemon juice dressing, no vinegar) complete the dietary. A cake of yeast three times a day is often very valuable. Rhubarb and soda may be of use. Associated constipation must be treated appropriately, according to the method outlined above.

The victim of protein putrefaction is sallow. There is a faint yellow staining of the neck under the ears. The tongue is coated, but not indentated unless there is an associated carbohydrate fermentation. Various forms of eczema, especially the chronic lichenified variety, are often present. Sometimes a slight congested redness is present behind the ears. Rheumatoid and neuralgic pains may occur. are frequently flatulence and a sense of abdominal heaviness, so called biliousness. Any of the symptoms occuring in carbohydrate fermentation may obtain. Generally, but not always, there is a high indican content in the urine. A curious thing about the condition is the apparent periodicity with which exacerbations may occur. Attacks of mental and physical depression, sometimes preceded for a few days by nervousness or even mild excitement and elation, may be entirely on a putrefactive basis and yet are often considered as material for the psychiatrist and wrongly diagnosed as mild forms of mantedepressive insanity. These more or less periodic

attacks suggest a temporarily increased absorption and may be due to ileo-coecal regurgitation. In treating this condition the accompanying constipation must be attacked.

The icthyol enema is exceedingly valuable, both by the removal of scybala and by its healing action on colonic catarrh. Meat, fish, eggs and cheese must be absolutely excluded from the diet. Milk, cream and cream cheese may be taken in moderation. Sugar should be avoided because of its tendency to produce catarrh and consequently increased absorption. Vegetables, potatoes, macaroni, cereals, bread and fruit, cream and butter make up the diet. The bacillus acidophilus is often very useful. Apparently the beneficial results of this treatment are due to a change in the intestinal flora. It is for this reason that the diet must be absolutely free from meat, fish and eggs for at least six weeks. Meat taken but once a week prevents the starving out of putrefactive organisms. Of course when these foods are added to the diet the putrefactive bacteria return, but the patient will be in better condition and will have learned the necessity of moderation in the consumption of flesh.

The writer does not venture to state the following as a fact, but only as a possibility calling for criticism. It has been his impression that the acute exudative forms of eczema pertain with more or less regularity to the patient suffering from carbohydrate fermentation, while the chronic, dry lichenified varieties are seen in the cases of protein putrefaction. Frequently associated with intestinal fermentation and putrefaction is the syndrome of vagotonia. What rôle the latter plays, whether that of cause or effect, will be for the future to determine. Probably a vicious circle is involved.

Regarding the importance of dental sepsis, it is needless to reiterate what is generally conceded. Carious teeth, pyorrhoea, alveolar abscesses, insanitary bridge-work furnish poisons which, though yielded in small amounts, are nevertheless yielded during the entire twenty-four hours of the day. It is useless to try to clear up a gastro-intestinal condition if the patient is swallowing several drams of pus every day. Darier, in his recent work on dermatology, emphasizes the importance of eliminating dental sepsis in the treatment of diseases of the skin, especially those diseases which apparently result

from obscure internal disturbances.

It is probable that most adult tonsils are foci of infection. Their chief function is to filter out disease germs entering via nose and mouth, and it is in childhood, the period, par excellence, of infectious diseases, that their function is of predominant importance. Like an advanced trench-system their purpose is to unmask and break up the preliminary attack, but when finally overwhelmed and infiltrated by the enemy, they become a stronghold for the foe and a menace to the defender. As a source of chronic infection they may cause manifold symptoms, gastrointestinal disturbance, rheumatoid conditions, susceptibility to coughs and colds, headaches, easy fatigue and "nervousness." The worst type of tonsil is the small, atrophic, buried variety, with its surface smoothed by the scarring over of the crypts. If, in the immediate neighborhood of this innocent-appearing traitor, the pillars of the fauces show a deep red, indolent injection, we can be still more certain that chronic infection is present and supplying a constant stream of toxic absorption. A patient, a man of 48 years, was sent to the writer with a history of precordial pain radiating into the left arm, and brought

on by exertion. His condition had been diagnosed as angina pectoris. The location of the pain, however, was precordial, and not, as is usual in angina, substernal. Never was there any sensation of dread, or of constriction of the chest, emphasized by Allbutt as being so significant in the diagnosis. thermore, questioning brought out the fact that it was only a particular kind of exertion which brought on the pain, namely, pushing a lawn-mower and swimming; in other words, the actions which put stress on the muscles of the shoulder-girdle. Climbing stairs never occasioned pain. I suspected fibrositis but could not detect muscular tenderness. I told the patient that I could not be certain of my ground, but thought that there were sufficient reasons for removing his tonsils, which were atrophic and innocuous appearing, but flanked by dull red faucial congestion. Tonsilectomy was performed and a month later the "angina pectoris" was in limbo.

The discussion of chronic rhinitis would necessarily involve considerable repetition. Enlarged turbinates, in contact with a deformed septum, prevent proper breathing and efficient drainage and give rise to a sodden, soggy, chronically diseased mucosa, which may in turn constitute a focus of infection. Constant head-colds, headache, post nasal dripping, nervousness, insomnia, loss of weight and a train of similar exasperations result. Sinus disease is a frequent sequel. Transillumination of the sinuses is an ambiguous procedure, but it is simple, may give useful information, and should be done as a routine. A mere smattering of rhinology is all the examiner needs in order to be able to recognize when a specialist should be consulted. Never must he lose sight of the fact that these conditions cause constant drain on the health. Diseased adenoids are frequently present in adults and play the same role as faucial tonsils, plus inflicting the added annoyance of impeded breathing. Even the humble lingual tonsil must be considered in the examination. Furthermore, the routine examination of this region may reveal the smooth atrophy of the base of the tongue, pathognomonic of syphilis and said to occur in 30 per cent. of all cases of this disease.

Chronic fibrositis, or chronic inflammation of the connective tissues, finds its most frequent expression in the so-called muscular rheumatism. It has been best described by Llewellyn and Jones. The fibrous tissues of the joints and nerves are also often m-volved, but it is only with the muscular variety that

this paper will deal.

The pathology consists of inflammation in the fibrous tissues, at first often acute and exudative, later chronic and productive, with a marked tendency to exacerbations. Symptomatically it expresses itself in muscular pains and aches, with mental and physical depression, partly toxic, partly the result of continuous discomfort. The particularly annoying feature is its constancy. Exacerbations may be occasioned by dietary indiscretions and by damp weather. Dry cold is less apt to bring on an attack. The pain and stiffness are characteristically worse on rising in the morning, and wear off to some extent as the patient moves around.

The locations of predilection are the trapezii, the dorsal muscles, the insertions of the neck muscles on the base of the skull, the insertions of the gluteal muscles on the iliac crests. Pinching and deep palpation over underlying bone reveal tender areas of induration and crepitation. Fibrositis is probably based on chronic infection and every possible focus must be thoroughly investigated. Tonsils, teeth, ac-

cessory sinuses, the genito-urinary system and especially the colon with its frequently concomitant fermentative or putrefective processes may be the responsible factors. An indulgence in sweets frequently precipitates an attack. Syphilis, gonorrhea, tuberculosis, chronic appendicitis and cholecystitis must also be considered. The treatment involves the discovery and removal of all pathological processes mentioned as having possible etiological significance. Locally, heat and massage are of value, not superficial stroking, but deep punishing rubbing of the muscles and tendinous insertions, thereby breaking up local inflammatory induration and dissipating it via the lymph-stream. Vaccines, potassium iodide and sodium salicylate by mouth, sodium iodide and sodium salicylate by vein, frequently give relief. Constipation and dietary disturbances must be treat-

One function of the history and examination will be the bringing to light of errors in personal hygiene which may be the starting point of the disabilities mentioned. Heavy woolen clothing, over-feeding, rapid eating, badly prepared food, lack of fresh air, exercise, sleep and proper emotional outlet, all these things have been anathematized by medical Jeremiahs with, unfortunately, but indifferent result. Whether minor endocrine disturbances are the ultimate cause, or possibly the result of, the maladies discussed, is for the future to decide. It will be a fascinating and profitable field for investigation. The periodic physical examination will not reveal beginning cancer, unless it be of superficial and accessible structures. It will, however, be a vital part of the type of research which MacKenzie says is absolutely essential for future medicine, namely, the clinical study of the individual patient. The purpose of this paper is to urge, what the writer firmly believes, that these conditions have a very real clinical significance, are not to be dismissed with a shrug and the diagnosis of neurasthenia, and possess definite, though not striking, objective findings which can readily be discovered if systematically searched for. 50 West 55th street.

AN OBJECT LESSON IN EPIDEMEOGRAPHY. JACQUES W. REDWAY, F.R.G.S.,

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Typhus fever and the bubonic plague are at our borders. They have gradually made their way westward as an aftermath of the world war. The bubonic plague is likely to invade the continent from the orient again in the near future; it has already reached us from Europe. When conditions are normal, typhus fever may be held in check by the exercise of reasonable vigilance; but conditions are far from normal and sporadic outbreaks are certain to occur. The bubonic plague, however, is not so easily held in

Historically, the bubonic plague is one of the oldest known of contagious diseases. It probably was the plague of boils visited upon recalcitrant Egyptians in the time of Moses and the Exodus. Proof positive of this may be wanting, but what certainly is known is the fact that the plague has hovered about Egypt from the earliest historical times to the present day.

Coming to mediaeval times historic evidence con-cerning the plague is clear. The plague described by Justinian, about the middle of the sixth century, was the bubonic plague. It has existed in the vicinity of the Nile delta for nearly twenty centuries. It is probable, however, that the disease was brought to

that locality from elsewhere. From Egypt it was carried to Constantinople. There it proved so virulent that more than 50,000 perished within a very short time. From Constantinople it was carried to Italy and, to the Mediterranean ports of France, and to the various Phoenician ports along the Barbary coast of Africa. It followed well-travelled trade routes, and infected the call ports of every one of them. Thus far the record of progress of the plague is fairly well authenticated. The records of mortality are absent. One may merely guess that the victims were numbered by millions.

The black death, which snuffed out the lives of more than twenty-five millions of people in Europe alone, likewise came from an outbreak of the disease which can be traced to Egypt. Whence it came to Egypt is not with certainty known; it may have hung about the lowlands of the Nile during the thousand years preceding it; it may have been brought by caravan from Chinese Turkestan, for it swept over Asia

Minor with a terrible death toll. The black death followed the regular commercial trade routes, which usually is the way with pandemic Of its spread through Asia Minor practically nothing is known. From Egypt westward its progress has been closely charted. To the ports and trade centres of the Balkan peninsula; thence to Italy, France, Spain, Great Britain and the Scandinavian countries its progress was swift and sure. Doubts have been expressed by various writers as to whether or not the black death was identical with the bubonic plague. I base a layman's opinion that it was the bubonic plague from the fact that it originated in the same locus and followed the same routes-always much-travelled trade routes. From the time of the black death the outbreaks have been roughly thirty years apart, or about the span of a generation.

Conditions wrought by the world war brought the bubonic plague into Europe again and from Europe it has spread to the American continent. Most likely it will lurk about warm weather ports for several years; but a spread beyond the sporadic stage is improbable. The chief danger centres about the gulf ports

India and China, and not Egypt, are now the chief centres of infection, from which the disease is likely to spread westward. In the ten years ending 1906 the mortality in British India alone reached a total of nearly four millions. Undoubtedly the railway traffic, both freight and passenger, intensified the spread of the disease. Caste in India accommodates itself to railway travel and passengers of different castes are huddled and packed like cattle into cars which cannot be kept free from infection. Inasmuch as the commercial traffic of India is with Europe, the chief danger to Europe lies in the handling of Indian commerce, especially from Bombay.

China is another area from which the bubonic plague for a score of years has not been absent, and the two ports from which it is chiefly spread are Hongkong, the name usually given to the port of Victoria, and Canton. In recent years the plague has been partly kept under control in the Hongkong district and likewise in the Kan lun peninsula across the channel. The mortality in Hongkong is scarcely more than three hundred per year. In all probability it always will be endemic to certain localities of the island; in places the ground is saturated with the bacilli.

In Canton and the adjacent regions of Kwantung Province the conditions up to 1911 were bad; it is not certain that they are above suspicion at the present time. The plague had been mildly endemic in

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or about Canton prior to 1894, but in that year it became a violent epidemic. During the outbreak of that year the toll of lines exceeded 190,000. Whether or not the outbreak originated in Canton is not known. A logical overlook of the case indicates that it was a fresh infection originating elsewhere—probably somewhere to the northward. Such an inference is logical because it spread rapidly both east and west from a locus north of Canton. Within a year it had reached Russia. Spreading eastward it crossed the Pacific, invading Australia, California, and Mexico. Up to the present time this outbreak seems to be the last pandemic. The outbreak of the discase in California may not have been communicated from Canton, but it certainly came from China.

So far as the inland provinces of China are concerned, except for Yunnan, the existence of the plague does not seem to have been extensive. Yunnan Province, however, is on the borderland of the region of suspicion. Through the wise efforts of colonial officials the disease practically is eradicated from the Dutch East Indies. It likewise has been eliminated from Australia and other British possessions. If a reinfection of the Pacific ports of the United States occurs, the chief danger must be sought in the importation of infected goods—chiefly rags, flea-infested merchandise, and rats.

The office of the flea is the carrier of the bacillus pestis needs not be considered. Any species of flea that abandons an infected animal to become parasitic upon a human being will infect the human being. Infection has been carried by body lice and by the insects commonly called "white ants." The last named insect, as a source of infection, possesses an interesting study. When the white ant bursts from the egg it possesses the wings necessary for a vigorous flight. Great swarms leave their nesting places, fly for a time, and finally settle. When they settle they drop their wings. Being partial to woody substances, they are pretty apt to invade dwellings, and thus they may come in contact with humanity. The thus they may come in contact with humanity. important point is the fact that, in the winged stage, they are migratory. Not only therefore they may spread infection; evidence that they have spread it is not wanting. White ants-which are neither white nor ants-may be eliminated as a source of danger so far as the United States is concerned.

As a disseminator of the bacillus-carrying flea, the rat is the chief menace. Other rodents that may carry the infected fleas are not migratory. Moreover, if fleas are absent from a locality to which infection has been carried, the danger of spreading the disease is much lessened. Infected fleas leave a dead animal and jump on anything living that will harbor them. In California the squirrels of contra costa country were infected; they died in considerable numbers. But the squirrels did not congregate about human habitations; therefore they were not an important source of danger.

In the vicinity of New York, during the world war, attempts to inoculate squirrels with plague bacilli failed. The squirrels died, but fortunately there were no fleas to carry the disease.

The rat is the chief source of danger in spreading the bubonic plague. None of the rat family is specifically an "oriental" rat. The rat that bears this name is the black rat or the brown rat, both of which have been in the American continent for many years. Rats are migratory in character—perhaps to a greater degree than any other animal. The brown rat is not specifically a house rat, but the species colonizes localities where humanity congregates. Wharves, stables, warehouses, markets, and vessels are places

where food is plenty; and there are the haunts of the brown rat. The black rat is a house rat, and seems to have been forced to the environment by the hostility of the brown rat. If field rats become infected they do not constitute a serious menace; they do not come in contact with humanity.

Because of their migratory habits rats are a constant means of spreading bubonic plague. Infected rats are carried in vessels of every sort from port to port; they are carried in merchandise, by pack train, by caravan, and by railway. The terminals of commercial traffic are rarely free from them. So long as food is a-plenty they remain in a locality. When the food supply is no longer sufficient they migrate—sometimes singly, sometimes in colonies.

The colonial government exterminated the rats in the city of Batavia; thereby they eliminated the plague. Two object lessons were inculcated: First, to make dwellings and warehouses rat-proof; second, to keep food out of their reach. When they have nothing to eat rats are pretty apt to migrate. Trapping rats in infected localities accomplishes but little; they breed more rapidly than they can be killed. Wholesale poisoning by means of gas most likely will prove successful in the future, but it is yet a problem to be worked out.

When the plague is endemic infection may spread in many ways, and the flea-bearing rat is not necessarily the chief agent. But in carrying the disease into new localities, rats have no superior competitors. The problem therefore is to get rid of the rat; and the rat also stands without a competitor as the most dangerous and the most expensive pest with

which humanity is inflicted. Much that has been rehearsed in the foregoing paragraphs can be said concerning the spread of typhus fever. The rat may or may not be a factor; at all events the rat is of less importance than are cats, dogs and other flea-bearing house pets. Whatever the micro-organism of typhus may prove to be, one fact is established: namely, it infects fleas, lice, bedbugs and other insects parasitic upon humanity. In the past, the mortality from typhus in military campaigns has been frightful. In these cases fleas and lice have been the chief carriers. When once sporadic cases occur in cities, the bedbug becomes an additional factor. Personal contact and nasal discharges also add to the dissemination of infection. Typhus has not been absent from the United States and Europe in many years. The great spread of the disease within the past few years in Europe is due almost wholly to the kind offices of body lice. Delousing is essential in preventing the spread of the disease; but the delousing should take place before embarkation and likewise after debarkation. The plague of lice was not greater in Egypt than it is today in Europe. Stamping out communicable diseases is commendable sanitation. Not infrequently, however, efforts are concentrated at the wrong end. The carriers and not their victims should be the foci of operative work. Asiatic cholera succumbed to control, not when it had "burnt itself out," but when the contaminated water supplies at Hardwar and at Mecca were cleaned and purified. The disease still lurks in Russia, however, and conditions there are favorable for a violent outbreak at any time, when this occurs, or spread through Europe is not unlikely. Yellow fever was conquered, not by drugs, but by the destruction of infected mosquitoes. Typhus will remain while infected body lice exist; and there is no valid reason for permitting their existence to continue. A community usually gets the government it deserves, but not always one that it most needs.

RES IPSA LOQUITUR IN MALPRACTICE CASES.

The Trend of Judicial Utterances.* ALMET REED LATSON, ESQ., New York.

The form in which our theme has been worded indicates the existence of some trend of opinion as opposed to a definite assertion of the law. Indeed, we seem to be approaching a formative period in the application of this legal doctrine to a branch of malpractice cases somewhat new, but now commanding attention. Perhaps we cannot do better at the outset than to define this doctrine "res ipsa loquitur," and for a definition we turn to the United States Supreme Court:

United States Supreme Court:

"The general rule in actions of negligence is that the mere proof of an 'accident' (using the word in the loose and popular sense) does not raise any presumption of negligence; but in the application of this rule, it is recognized that there is a class of cases where the circumstances of the occurrence that has caused the injury are of a character to give ground for a reasonable inference that if due care had been employed by the party charged with care in the premises, the thing that happened amiss would not have happened. In such cases it is said, res ipsa loquitur,—the thing speaks for itself; that is to say, if there is nothing to explain or rebut the inference that arises from the way in which the thing happened, it may fairly be found to have been occasioned by negligence."

"In our opinion, res ipsa loquitur means that the facts of the occurrence warrant the inference of negligence, not that they compel such an inference; that they furnish circumstan-

the occurrence warrant the inference of negligence, not that they compel such an inference; that they furnish circumstantial evidence of negligence where direct evidence of it may be lacking, but it is evidence to be weighed, not necessarily to be accepted as sufficient; that they call for explanation or rebuttal, not necessarily that they require it; that they make a case to be decided by the jury, not that they forestall the verdict. Res ipsa loquitur, where it applies, does not convert the defendant's general issue into an affirmative defense. When all the evidence is in, the question for the jury is whether the preponderance is with the plaintiff."

The Bar has been taught that the doctrine res ipsa loquitur never applies in malpractice cases; that a charge of negligence in such cases must be proved by competent evidence; and that the only competent evidence to establish the allegation of negligence is the evidence of experts.

Liability in these cases, therefore, is not to be predicated upon the result of the practitioner's effort, else few would have the temerity to practice a profession. On the contrary, the physician or surgeon is charged with the obligation of possessing requisite knowledge and skill; with the duty of exercising reasonable care; and with the further duty of using his best judgment. Let me quote our own Court of Appeals upon this subject. The rule laid down by that tribunal expresses the settled law not only in this state, but in substantially all jurisdictions.

all jurisdictions.

"The law relating to malpractice is simple and well settled, although not always easy of application. A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices, and which is ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of practicing medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment. The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong only to a few men of rare endowments, but such as is possessed by the average member

of the medical profession in good standing. Still, he is bound to keep abreast of the times, and a departure from approved methods in general use, if it injures the patient, will render him liable, however good his intentions may have been. The rule of reasonable care and diligence does not require the ex-ercise of the highest possible degree of care, and to render a physician and surgeon liable, it is not enough that there has physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown, or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result. This includes not only the diagnosis and treatment, but also the giving of proper instructions to his patient in relation to conduct, exercise and the use of an injured limb. The rule requiring him to use his best judgment does not hold him liable for a mere error of judgment, provided he does what he thinks is best after careful examination. His implied engagement with his patient does not guarantee a good result, but he promises by implication to use the antee a good result, but he promises by implication to use the skill and learning of the average physician, to exercise reason-able care and to exert his best judgment in the effect to bring about a good result."

Conceding the requisite education and training, the practitioner is not held accountable for a mistake of judgment; he is held accountable for a failure to use his judgment or for a failure to exercise the skill which he possesses. There were read before your society a few months ago a paper entitled "Comments on a Court Case," where apparently a question was litigated somewhat germane to the one we are about to consider. In the absence of the record of the trial and with nothing before us but the contents of that paper, it would seem that the parties sought to litigate the issue whether or not the x-ray had become so definitely an instrumentality available to the medical profession that the failure of a practitioner to utilize the same for diagnostic purposes in determining the existence or nature of a fracture was in itself negligence.

It would appear from the contents of the paper that a liability was imposed upon the defendant by finding an affirmative answer to that question. It is unquestionably true that the practitioner is called upon to keep himself abreast of the times and to be familiar with such scientific progress as may be made in his profession. To determine, however, whether or not to utilize a given instrumentality under circumstances and conditions presenting themselves to the practitioner, may easily in-volve the exercise of professional judgment and fall within the field where professional men, equally qualified, might differ. It would seem scarcely consistent with the rule above quoted to charge upon the practitioner the obligation to decide, at his peril, in each such

It is in this particular direction that our attention is briefly invited for ther purpose of noting the trend of thought running through the few malpractice cases based upon the use of the x-ray.

There is little to which we can point constituting settled law upon this inquiry, but here and there, first in one and then in another jurisdiction, judicial utterance has indicated some uncertainty as to whether or not the use of this instrumentality by the medical profession should fall within the general rule above quoted.

One class of judicial utterances in sister states is to the effect that there could be no doubt that the rule requiring care and skill in other cases applies here as well, while in some other jurisdictions it has been reasoned that inasmuch as a burn had resulted from exposure to the rays, and that the apparatus was under the control of the defendant, and that in the great majority of exposures no burn results, therefore the doctrine res ipsa loquitur was available to the patient. As yet the Appellate Courts of our own state have not passed upon these questions, but they must shortly be called upon so to do.

This instrumentality of the medical profession has been

^{*}Read before the Society of Medical Jurisprudence, New York.

known for approximately twenty-five years, during which time substantial progress has been made in learning its character and in devising methods for its use, but how far science has yet fully mastered its characteristics can only be determined in the light of future exploitation and investigation. It is common knowledge, however, that now and again a patient exposed to the x-ray will complain of a "burn," frequently not developing until long after the exposure, and sometimes classed as a burn of the first degree, at other times a burn of the second degree, and in still other cases as a burn of the third degree. These "burns," as the basis of malpractice litigation, both in diagnostic and in therapeutic cases without indication of any line of cleavage, have provided occasion for the somewhat diverse judicial utterances to which allusion has been made, and it may be helpful to follow the trend of reasoning in each, noting the logical conclusion thereby indicated.

We, of the Bar, are told by the medical profession that in utilizing the x-ray, an operator contemplates the co-relation of four factors: amperage, voltage, distance and exposure; that by algebraic formula this co-relation is measured in terms of a "skin unit"; and that variation among the several factors is the subject of determination by the operator in the exercise of his skill, his care and his judgment under the particular circumstances which confront him. Perhaps this form of ex-pression is not scientifically accurate and presumably there are those present who will be courteous enough to correct any inaccuracy, but for our purpose it is sufficient to observe that we here hold in contemplation the three elements upon which may be predicated a liability under the rule laid down by the Court of Appeals as above quoted, namely, the possession of the requisite education and skill, care in utilizing that skill and the exercise of the operator's best judgment in the premises. Reverting, for a moment, to the problem considered in the paper entitled "Comments on a Court Case," combining with the doctrine there laid down, the suggestion that res ipsa loquitur may find application, it follows that the medical practitioner would be placed in a position of great jeopardy. Primarily he would be forced to utilize the x-ray at the peril of being charged with negligence in failing so to do, and then this instrumentality having been utilized, a resulting burn would raise the presumption of negilgence without any evidence that the operator lacked skill or failed to exercise due care or failed to use his best judgment.

If this reasoning be sound, one of two things must result, namely, either the settled law in malpractice cases is to be modified, or, on the other hand, a new body of law is to be enunciated applicable to x-ray cases, as distinguished from the use of other scientific instrumentalities available to the medical profession, although as yet no attempt has been made to point out the principle upon which any such differentiation is to be asserted.

When, however, we consider that view which regarded the established rule requiring care and skill in other cases as applicable in the use of the x-ray, a more logical sequence of thought is evolved. The operator is thus charged with the duty of possessing the skill required in the use of his apparatus; he is required to use due care; he is called upon to exercise his best judgment in making the exposure, but he is not a guarantor of success, nor is he held to be immune from those frailities of human nature called "mistakes" or "errors of judgment." He is accorded the same status, for example, as the anesthetist who is skilled, who exercises due care and acts upon his best judgment. The patient fails to revive, but in such cases the courts have refused to apply the

doctrine res ipsa loquitur, demanding, on the contrary, some affirmative competent evidence to establish the alleged negligence of the anesthetist. As we have seen, negligence might consist in a failure to possess the education and skill required of one practicing his profession, or again, it might consist in a failure to carefully examine the patient before administering the anesthetic, or in a failure to prepare him for the same, or in a lack of care during the administration of the anesthetic itself, or again, it might consist in a failure to use his best judgment in the choice of an anesthetic, or in the quantity administered, or in the length of time the patient was kept under its influence, etc., etc. Hundreds of patients are anesthetized daily in this city alone. Rarely does a fatality occur, in each instance the anesthetic is "wholly under the control of the defendant," and yet it is held the death of the patient raises no presumption of negligence. Wherein lies the distinction? Other and presumably more helpful analogies will occur to the medical practitioner.

Such being the settled law, it is difficult to discern the theory upon which x-ray cases were to be taken from the general rule and treated as sui generis. would seem rather that judicial thought has not kept apace with the progress of science, and that it remains for the jurists of this, our own state, to rescue the question from the doubt which now surrounds it. It may be that in reaching a conclusion the courts will feel the influence of a great economic factor now at work, which has already found expression in health insurance, work-

men's compensation laws and the like.

We must not be unmindful that the x-ray is not exclusively in the hands of the medical profession. Whether or not some distinction will ultimately be drawn between the non-medical operator and the medical operator remains to be seen, but, as yet, that question appears not to have been judicially considered. Following the reasoning in which we have indulged, the ground for such a distinction is not apparent. The lay operator holds himself out as a scientist, peculiarly skilled in this distinct branch; by his education and his experience and by the acquisition of his skill, he constitutes a precise instrumentality available to the medical profession, and he would be answerable for a failure to possess the knowledge, skill and experience attributed to him. Assuming the possession of these prerequisites, it would seem, by parity of reasoning, that his liability could be predicated only upon a failure to use due care, or a failure to exercise his best judgment in the performance of his duty.

There is still one other branch of the question which the medical profession may, perchance, be called upon to consider. When, in the judgment of a practitioner, the use of the x-ray is desirable, an operator is recommended. It would not be surprising if, some day, the practitioner were called upon to justify his recommendation, particularly if the operator recommended be A somewhat larger field of conjecture non-medical. may be opened by contemplating such a recommendation for therapeutic purposes. The circumstances are not inconceivable where the doctrine respondent superior may be invoked. Perhaps in the end an attempt will be made, by means of legislation, to bring the entire instrumentality exclusively within the domain of the medical profession, whether for diagnosis or for therapeutic

If these views shall be sufficiently suggestive to stimulate some thought or expression of opinion, they will have served their purpose. The attempt has been to recognize the existence of an interesting question, rather

than to supply the answer.

Discussion

Discussion

Dr. Hoag: The two elements that might be considered, generally speaking, and especially in reference to the x-ray, would be the patient and the operator. In the administration of drugs, and in any so-called therapeutic treatment, in the application of massage and other physical agents, the physician realizes that he has to consider well his patient. There are certain patients who have an idiosyncrasy against certain things. One can take ten grains of quinin without bad effect and if another takes two grains he will have all kinds of trouble. I am not familiar with the x-ray, but I presume the rule applies in the same way there. I know that in the application of heat there are some institutions where heat tar above the boiling point can be applied. Burning is prevented by the application of Turkish towels, so that the patient gets the therapeutic effect and no harm results. But if a fraction of an inch of the toweling is not in contact with the surface of the body a burn would result. That would come under the ruling with reference to the exercise of care. In considering the x-ray we must take into consideration the fact that it is used diagnostically and it is used for therapeutic purposes. I cannot conceive that a burn would result from the use of the x-ray for diagnostic purposes, because the time of exposure is so short, but I can conceive of a burn arising when the x-rays are used for therapeutic purposes. When it comes to the question as whether the x-ray is in the hands of the laity or of the profession, I believe there are experienced laymen who have worked with the x-ray under the direction of a physician and who become so expert that the physician comes to who have worked with the x-ray under the direction of a phywho have worked with the x-ray under the direction of a physician and who become so expert that the physician comes to feel that they are more competent than he is. The physician knows the general theory and he explains it so well to his nurse or assistant that he often feels more confidence in the nurse than in himself, and she succeeds. But if under such circumstances a malpractice suit should be brought it is the physician who would be responsible and not the nurse. Shall the x-ray be entrusted to the laity? If not, it increases the responsibility of the medical profession a great deal.

With reference to the question of skill, learning, care and judgment, I do not know how we are going to determine skill.

With reference to the question of skill, learning, care and judgment, I do not know how we are going to determine skill. There are surgeons skilful in one or two operations according to the opinion of the public and of other practitioners, and yet if they are duly modest they will tell you they have skill in only one or two things. When it comes to the question of care and judgment, it is a wonderful thing to think of the lack of care and lack of judgment we all sometimes show. There is probably no man who does not tremble to think of his lack of judgment. He does a certain thing one day which at the time seems proper and the next day he says to himself, "I should not have done that." He blithely goes his way, but the results of the failure of judgment may still be there. This is a very important subject for both the doctors and the lawyers.

Mr. Ehrhorn: In regard to the question of legislation dealing with this subject and whether the layman should be allowed to use the x-ray or not, I would sav the x-ray might be used by the layman, but the physician should determine whether the x-ray should be used for diagnostic purposes or whether the x-ray should be used for therapeutic purposes. This is a question for the medical man to determine and if he makes an error it should be settled according to the rule of law governing negligence cases. If he determines that the x-ray should be used for diagnostic purposes he probably determines that be used for diagnostic purposes he probably determines that this would not be a medical use of the x-ray. The layman would do these things under the direction of the physician, and if the physician exercised ordinary care in the selection of a man who understood the ray, his duty would be over The layman would then be responsible under the law as applied to all persons. But in the application of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the control of the ray to the appeared to the The layman would then be responsible under the law as applied to all persons. But in the application of the ray to therapeutic purposes the question of treatment enters for which the medical man must be held responsible, whether he actually uses the x-ray himself or leaves its use to a layman. There are some cases in the Courts of Appeal that take up various phases of the x-ray. In the paper read before the Society in January some of these questions were taken up. The question was taken up as to the interpretation of these skiagraphs, and the Court held that the ordinary physician is not always competent to interpret these skiagraphs. It requires an expert to interpret them. The Court of Appeals went very thoroughly into that field. It seems that there is a field here that is still to be developed and it will require judicial determination.

The fact that in various States different courts held different cominions need not disconcert us, because it is known that if we examine into any question we shall find different opinions in different localities. In one locality we find eminent men, occupying the pinnacles of the profession in that locality, deciding a certain question in one way, and if we go to a neighboring State we shall find that they have their pinnacles who have decided the same question in exactly the opposite way.

Not only is that true of different States, but you do not need to go out of this State to find the same thing. For instance, in the Borough of Brooklyn the Appellate Court decides a certain matter in one way and the Appellate in this jurisdiction, For instance, equally eminent, decides the same question in exactly the opposite way. Lawyers who are astute, when they want this question decided as the Appellate decides it in Brooklyn, find a way to take the case into that jurisdiction, and when they a way to take the case into that jurisdiction, and when they want the question decided as it is in this jurisdiction they keep the cases here. The same thing happens in connection with the State and Federal courts. I had a case in which I would have been beaten in the courts of New York State so I took it to the Federal Court. There always will be different opinions in different jurisdictions on questions of law and that need not worry us. But we are indebted to the reader of the paper because he has brought out a fruitful field for discussion. Dr. E. E. Smith: There are just one or two points I might mention in connection with the address of Dr. Morris to which the speaker referred. One criticism of that case was that when the Court asked to dismiss it the statement was made that there was evidence of some negligence. The Court apparently intended to say there was some evidence of negligence.

that there was evidence of some negligence. The Court apparently intended to say there was some evidnce of negligence. That was the point Dr. Wilcox brought out. Another point of criticism was with reference to the verdict brought in. Another interesting point was that the results in that case were not questioned. The practitioner did not make the diagnosis of impacted fracture, but he treated it as though it were an impacted fracture and he out the results that would be obimpacted fracture, and he got the results that would be obtained by good treatment, yet because he had not used the x-ray to examine the fracture, and made the diagnosis of impacted fracture, a verdict of \$1,200 was brought in against the defendant.

Mr. Cole: As to the reliability of the x-ray itself,-Mr. Cole: As to the remaining of the state as to use such an agent that we may depend upon it so fully as to use it for these various purposes? We say the results were so the person using the s-ray. We it for these various purposes? We say the results were so and so and charge it up to the person using the x-ray. We had a president of this Society who was very skilled in the use of the x-ray. It was due to the irritation of the x-ray, as I remember it, that brought about his death. Now I had a case last year in which there was a feature of a bone, an accident case, and the patient was taken to the hospital. The x-ray was used, and the matter was afterward settled by compromise. The head surgeon swore there was a fracture, though he told me the x-ray did not show a fracture, but he made an he told me the x-ray did not show a fracture, but he made an affidavit that there was a fracture because he thought there was one. Now we do know that the x-ray is more reliable in cases of fracture of a bone than in lesions of the mucous mems-ray. I had an experience only last year with a surgeon in a neighboring city, said to be the ablest in the country in any operation about the head, yet his assistant was doing almost nothing else but recommend an s-ray examination of the teeth. He was sending them to a certain x-ray man because he said they could read his pictures better than those of any other x-ray man and he was more reliable. This assistant said the surgeon was very busy and could not see everyone who came to the office. One man came who said he wished to see the surgeon as he had come to see him and no one else. This man came with double vision and no doubt had very serious eye trouble. He examined this man's teeth and recommended that he have x-ray pictures taken. The man insisted upon seeing the doctor himself. He said he had a dentist who had cared the doctor himself. He said he had a dentist who had cared for his teeth and he had had an x-ray of his teeth and did not need another. This suggested that possibly the x-ray is being carried to the extreme by some. This was a very competent man and an able surgeon. It is so easy when we see any agency of this kind used so generally to ascribe the results we see to negligence when they may be due to something else or to something in connection with an agency we do not fully understand

fully understand.

Mr. Solomon: I am inclined to take the view of the reader of the paper that these are irreconcilable decisions. These deof the paper that these are irreconcilable decisions. These decisions in the future may present quite a problem, possibly fraught with a great deal of danger. This much is certain, either that the decisions referred to and reflecting upon this instrument are an exception to the general doctrine in malpractice, or they are an indication of a departure from the general and according to the first the general doctrine in the general and according to the second of general and accepted practice. Either the x-ray will have to be isolated completely from the general body of law applicable to malpractice, or after it is permitted to sway the trend of decision in the other direction it will involve very severely the body of the law relating to malpractice. If this rule with respect to this instrument permits of the operation of the doctrine of "Res ipsa loguitur" it is capable of permeating the tende of the law in relation to malpractice. If you extend the use of this instrument to laymen, what is to prevent the testimony of the layman being given against the doctor who has used this instrument in the practice of his profession? Unless we have legislation or unless some other remedy is

found the condition with which we are confronted is going to have an effect that may completely undermine the principles applicable to malpractice cases and the practitioner may be

applicable to malpractice cases and the practitioner may be convicted on the testimony of the layman.

Dr. Zwisohn: The reader of the paper asked the difference between the use of the x-ray as a therapeutic remedy and as a diagnostic agency. There is quite a great difference, and for that reason the courts gave different decisions in these cases. As a remedial agency the physician has the right to say whether the x-ray will in his opinion be beneficial to the patient. One physician will say it will do good and another physician will say it will not do good just as one doctor prescribes one drug and another doctor something else. As to the advisability of using the x-ray as a remedial agency the doctor must decide. Used as a diagnostic agency, if pictures are taken and show a tracture, everybody then knows that there was a fracture, but if a physician treats a patient for fracture and there have been no pictures taken there is no proof that fracture was been no pictures taken there is no proof that fracture was present and then the physician may be charged with malprac-tice and it may be claimed that he did not make a correct diag-In my opinion the reason the judges decided differently in these cases was because in one instance the x-ray was used for remedial purposes and in the other for diagnosis, and the x-ray used for remedial purposes is one thing and the x-ray used for diagnostic purposes is another thing. But the main used for diagnostic purposes is another thing. But the main objection in Dr. Morris's case is that the decision was so il-The attending physician treated the case as though it were a fracture and the result was perfectly good and could not have been better. There was no evidence that even if an x-ray picture had been taken the treatment would have been any better, so why were there any damages awarded? That any better, so why were there any damages awarded? That is so very illogical, and that is the reason why the courts and the lawyers should not take up what belongs to the physician.

Dr. Walter Henry Conley: There is a decided difference in

the x-ray as used for diagnostic purposes and the x-ray as used for treatment. The technician may use it simply for diagnostic purposes, but only a well trained and efficient man should do the work. Laymen do not know about skin units and if they are not properly trained will burn the patient every time. For diagnostic purposes the exposure is almost instantaneous, and very seldom, probably never, results in a burn, but for treatment you have to have a prolonged exposure and sometimes the treatment has to be extended over two, three or four months, and sometimes even the specialist does not know that he has produced a burn for several months. For that reason nobody but a physician should give the x-ray treatment. In the Municipal Hospitals only qualified physicians are permitted to use this instrumentality in the treatment of disease. For diagnostic purposes a layman takes the pictures for the diagnosis of fractures. Now in relation to Dr. Morris's paper, we had a case brought into the Metropolitan Hospital last night with a compound fracture of both bones of the leg. That man was in such serious condition that we could not take an x-ray picture. If he lives a few days and we get him into better condition we shall then take an x-ray picture, but if the man dies all we can say is that we could not take a picture on account of the patient's condition and in order to conserve the strength of the patient. The physician in Dr. Morris's case knew he was dealing with a fracture and I do not see how they could get judgment against him for malpractice in a case of that kind.

Dr. F. S. Weingarten: As to the responsibility of the physician is the property of the physician in the property of the physician is the property of the physician in the property of the physician is the property of the physician in the property of the physician in the property of the physician is the property of the physician in the property of the physician is the property of the physician in the property of the physician is the property of the physician in the property of the property of the property of the patients of the patients of the property of the patients of the property of

sician for the nurse using the x-ray in a surgical clinic the surgeon is responsible for the act of his assistant; it is not the assistant who is held responsible.

the assistant who is held responsible.

As to the use of the x-ray in the diagnosis of fractures, certainly it is a help, but do you think we had many more lame men going about twenty-five years ago than we have today? A well-trained surgeon by the sense of touch can diagnose a broken bone as well as the x-ray. I look upon the x-ray in the diagnosis of fractures as I do upon the Wassermann reaction in syphilis. If you have a case of syphilis and the Wassermann test gives a positive reaction you have your diagnosis, but if you have a case that you know is syphilis and the Wassermann reaction is negative, then the test if no use to you. The man properly trained as a surgeon should be able to diagnose a fracture without the x-ray, though in cases of to you. The man properly trained as a surgeon should be able to diagnose a fracture without the x-ray, though in cases of impacted fracture the x-ray is a help. In fractures twenty-five years ago we got just as good results as we are getting today. Dr. B. S. Talmey: I do not see how the doctrine "Res ipsa loquitur" can be applied to physicians at all. If you apply it to physicians then in every case in which the man dies the physician could be sued for malpractice. "Res ipsa loquitur," the thing speaks for itself, the man is dead.

Mr. Latson: Dr. Talmey has emphasized the point I sought to bring to your attention. Unless, therefore, the x-ray cases shall be held to fall within the general rule, we must face either a new body of law applying to the x-ray cases only or.

either a new body of law applying to the x-ray cases only, or,

on the other hand, an infringement upon the rule itself and, perchance, ultimately its serious modification. Any attempt to differentiate between the use of the x-ray for diagnostic purposes and its use for therapeutic purposes seems illogical. In the ordinary practice of medicine, a physician or surgeon mak-ing a diagnosis is protected under the three rules of skill, care ing a diagnosis is protected under the three rules of and judgment, just as much as he is during treatment.

NASAL POLYPI AND ASTHMA.

ARTHUR PALMER, M.D., New York.

The intimate association of asthmatic attacks and nasal polypi is well illustrated by the case of a young woman referred to me for diagnosis and treatment,

Every morning for two years following a minor nasal operation, the exact nature of which I was unable to ascertain, this patient has had a severe attack of a choking sensation, and marked dyspnea. During the past three weeks she had been hoarse. She had steadily lost weight and had been unable to continue her position as bookkeeper. For about a year she had been taking considerable "cough and stomach" medicine, and had had all her upper teeth except the incisors extracted.

I found both nasal cavities blocked with polypi and the septum deviated to the right. Examination of the heart and lungs and abdomen were negative. I removed the polypi and part of the left middle turbinate bone and the following morning she informed me much to my surprise that she had had no asthmatic attack for the first time in about two years. Three months later she returned to me with a slight recurrence and again some small polypi were removed with the same effect. to the present time she has had no further attack.

2178 Broadway.

ADHESIONS IN THE FOSSA OF ROSEN-MULLER.

HAROLD HAYS, M.D., F.A.C.S., New York.

It is a fact well understood today, that any abnormalities in the region of the eustachian tubes are likely to give symptoms that are particularly referable to the middle ear. Among these symptoms may be mentioned chiefly, chronic suppurative otitis media, and chronic catarrhal otitis media.

Among the abnormalities most frequently found to adhesions in the fossa of Rosenmuller. These are adhesions in the fossa of Rosenmuller. adhesions are the aftermath of some small adenoid vegetations in childhood in which the glandular tissue has disappeared and small bands of connective

tissue are left.

What are the results of such adhesions? The fossa being situated behind the promontory of the eustachian tube, is covered by an infold of mucous membrane normally containing some muscular tissue which tends to the free action for the opening and closing of the tube. It can readily be seen that any inflammatory process of this mucosa or the presence of adventitious tissue such as adenoid masses or adhesions, will tend to destroy the normal balance of the muscular action of the tube. The result is that instead of the proper air pressure being maintained in the middle ear, there is too much or too little air, with the result that an altered condition of the action of ossicular joints takes place.

The presence of adhesions in the fossa of Rosenmuller can be determined by careful examination of the nasopharynx either with a mirror, pharyngoscope or nasopharyngoscope. One must locate the eustachian tubal orifice first and then examine the deep sulcus behind it. Here one may see small fine bands of connective tissue, which stretch from the posterior 2187 Broadway.

pharyngeal wall to the promontory of the tube. I am of the opinion that the adhesions play such an important part in progressive deafness that in every instance I attempt to break them down so as to free the muscles which surround the tubal orifice.

The procedure for freeing these adhesions is exceedingly simple. In very excitable subjects it may be necessary to give gas oxygen anesthesia, but in the majority of cases no anesthetic is necessary. After washing the hands thoroughly, the index finger of the right hand for the right fossa and the left hand for the left fossa is inserted behind the soft palate and gently moved about until the fossa is located. The tip of the finger is then gently inserted and the fossa is swept clear from above, downward. The procedure, although slightly distressing, is not painful. The patient expectorates a small amount of blood, but after an half hour or so there is no evidence of any manipulation. It may be necessary to repeat the performance once or twice, but this depends, of course, upon whether one can see what new adhesions have formed.

SIX YEARS' EXPERIENCE WITH VACCINES.

B. S. TURNER, M.D.,

Chicago, Ill.

After six years' use of serums and vaccines—principally stock—my retrospective recollections are very satisfactory. The realm of medication has been greatly reduced and the working horizon much enlarged.

Real medication of known value has lost little, but the ability to hit the bull's eye has so greatly increased that to stop using vaccines would be like taking the slighting apparatus off great guns.

I am convinced that surgery should welcome vaccines as a preparatory treatment, or a prophylactic against infection. If tuberculin were useful where the patient showed a tuberculous infection, why not use the other vaccines when the presence of mixed infections was easily determined, as in all those chronic or subacute pulmonary or throat cases which require everlasting medication and never fully recover?

If natural immunization gave protection and artificial immunization checked the progress of destructive diseases, why not imitate nature and protect the patient, as far as possible, against any of the common forms of infectious diseases to which he might

There are too many patients who fail to improve under ordinary treatment and too many violent infectious cases which are foredoomed, in every physician's practice, to excuse the use of any treatment which holds out a hope; and after pulling a single one back from the brink of the grave, the veriest amateur must give pause to think.

The attempt to use stock vaccine in an intelligent way arouses a new and fascinating interest in the successful practice of medicine. One soon feels newly armed with weapons of greater power and precision—so much so as to lead almost to overconfidence. If their use has not been too long delayed one might almost think that "the more virulent the pathogenicity the more certain the cure." There should be no typhoid fever and no case should last over two weeks, and carriers should be easily eliminated, all through the use of stock vaccines. Death from typhoid seems almost a crime.

If the use of stock vaccines never accomplished

anything more than this, what a victory is won! Much misery exists from mild infections, but common great dangers to life come from a few. Study the rudiments of bacteriology and the evidence of disease half as much as one would Materia Medica and therapeutics and the careful use of vaccines will produce far greater and more lasting results than medicine, Christian Science and osteopathy combined. Vaccines are comparatively easily made "in America." They are cheap and the necessity for them creates the supply. Monopoly is impossible and embargoing cannot deprive us.

The use of vaccines is always followed by less prescription writing. As a preparation for surgery or obstetrics, their use will be rewarded.

A Doctor's Story

DOCTOR AND PATIENCE.

HAROLD M. HAYS, New York. (Continued from March issue.) CHAPTER X.

I had just managed to fall off into a fitful sleep when I heard a far-away tinkle which, in my dreams, seemed like little golden bells. Then the sound impressed itself more forcibly on my consciousness and I sat up in bed, suddenly, fully awake. Out of my muddled brain came the distinct thought of the telephone which up to that time had never disturbed my after-midnight slumbers. Sleepily I stumbled across the dark room in my bare feet.

the dark room in my bare feet.

"Hello, Dr. Snaith," a sleepy voice inquired. "This is Mr. Caldwell. You don't know me. Say, Doctor, do you mind coming over here?"

"What's the matter?" I asked.

"What's the matter?" I asked.

"Dunno exactly. One of the servants is raising an awful racket. She's been yelling for the last hour. Can't quiet her. Cramps or something."

"All right, I'll be over in ten minutes," I said as I hung up the receiver and jotted down the address, and to myself said, "Oh hell!"

"It's bad enough to be awakened in the wee small hours of the morning by a lucrative patient," I thought. "But of all the cussed luck I ever heard, the worst is to have someone call you in for a servant girl just because you happen to be handy. Why didn't these people call in their regular physician? They probably have one."

I kept on fuming, as a man will who is awakened after three hours beauty sleep and has no one to work his grouch on. If a man has an amiable wife, it's different. I kept at it while I immersed my face in cold water, soaked my hair, rinced my mouth and put on my clothes. I filled a pipe, lighted it—and then I really woke up and began to realize that I was a cotor whose services were needed and that nothing else counted. Mr. Caldwell lived next door.

In a few moments, I was ushered into the hall of Mr. Caldwell's home. Everything seemed pretty quiet and the old man in his pajamas and rumpled grey hair, apologized for getting me out of bed.

grey hair, apologized for getting me out of bed.
"I'm sorry, doctor," he said consolingly. "If it had been one of the family, they'd have had sense enough to have a bellyache in the day time."

"That's alright, Mr. Caldwell," I replied. "Servants are entitled to bellyaches the same as other people, although I'll admit that their lack of education doesn't allow them to have one at a convenient hour."

The old man chuckled. Then he introduced me to his wife who came out of a shadow into the semidarkened hall like a materialized sensitive at a spiri-To stir us up a bit, the patient tualistic seance. whom we were discussing emitted a heart-rending yell as though to notify us that she waited on our coming.

Mr. and Mrs. Caldwell took me through the apartment to the servant's room, which had been somehow squeezed in at the last moment between the kitchen and the pantry. On the flat, iron cot, lay the poor girl whose face was distorted with pain. The bedgirl whose face was distorted with pain. The bed-clothes had been thrown off. The not overclean night-dress hung down damply from her shoulders. Her knees were drawn up.

"Where is your pain, Sister?" I asked in a sympathetic voice.

"Here it is, doctor, here it is," she whispered hoarsely and pointed to the lower right side of her abdomen. "I ain't goin' to stand it. I'm goin' crazy. Oh, doctor!"

I examined her carefully and tenderly. I was conscious that Mr. and Mrs. Caldwell were watching every move. But I wasn't doing any grandstand playing. I found a markedly tender spot on the rigid, distended abdomen over the appendix region.

I took her temperature; it was 104°.
"You're alright, Mary," I said when I had finished.
"I'll take good care of you, so don't worry. I'll get some medicine ready which will relieve the pain." patted her head and then beckoned Mr. and Mrs. Caldwell out in the hall.

"The girl's got acute appendicitis. She ought to be operated upon at once.

"My gracious, what shall we do?" ejaculated Mrs. Caldwell. "I don't know where any of her people are and I can't take the responsibility. I know if you mention operation to her she's tell you flatly she won't have it done."

"You leave that to me, Mrs. Caldwell," I answered seriously. "It's a matter of life and death with that girl and every moment counts. If you don't want to take the responsibility, I will."

"Where'll you take her to be operated?" asked Mr. Caldwell. "The girl hasn't any money except her small wages."

"I know that," I said, "so I was going to suggest that we send for the ambulance and have her taken to a hospital where I can operate her. We can put her in the ward where the charge would be nominalabout nine dollars a week. Would you be willing to meet that expense?"

'Surely," answered both of them eagerly.

"What would you charge for the operation, doctor?" asked the husband.

"Nothing," I answered promptly. "If you are willing to help the girl by paying her hospital board, the least I can do is to help the good work along without thought of remuneration. I'll give her a hypo of morphine now, tell her what her trouble is and what has to be done and then ring up the hospital. I'm sure they have room. We're not very busy at

Within the next fifteen minutes everything was settled and I was ready to go. Mary was resting quietly.

"You will let me pay you for this visit, doctor?" "Not one cent," I replied laughingly. "If Mary

gets well I shall consider that I have been amply paid."

"Thank you, doctor," smilingly replied the old "You're the right kind. I won't say anything now but-we're a thousand times obliged to you.

The next three hours were busy ones. By six o'clock Mary had been put back to bed minus a swollen, abscessed appendix which was on the point of bursting and had a drainage tube in her abdomen instead. By seven o'clock I was home once more.

I was as wide awake as if I had had a good night's sleep. My restless nerves were quieted. I was im-mensely satisfied with myself. I had made a quick diagnosis, had operated within three hours and had my opinion corroborated. But what was of most importance I had no doubt saved a poor girl's life by my prompt action. I wondered what would have happened if I had waited until morning to operate. In my own mind I felt assured that those few hours of delay would have resulted in a ruptured appendix, peritonitis and probably death.

I felt a bit cocky about my confidence in myself. Of course it wasn't a hard case to diagnose, but I never flickered an eyelash when I told Mr. and Mrs. Caldwell what had to be done. And as soon as I made the diagnosis my plans were formed in a second's time. There was no wavering. She just had to go to the hospital and be operated and I felt she'd have gone if I'd had to carry her on my back all the way. Somehow or other I felt a bigger man all around. It reminded me of the time when I was a kid sitting on the beach at a summer resort in my bathing suit wondering whether I would have nerve enough to save a person from drowning. Suddenly I heard a cry, "Help, help!" and saw a head bobbing up and down on the waves. Before I knew it I was in the water and a few moments later had brought in one of the boys who had gone out beyond When I saw his face I was mad clear his depth. through, for it was a mean little sinner who had been courting my best girl. Yet I felt that I couldn't have helped trying to save him.

It had always seemed to me that a man with a clear head and a fair amount of brains, who had been brought up properly, was bound to do the right thing in the right place. It wasn't a question of intellect. It was a question of proper intuitive judgment and the confidence one had in himself to go ahead and do what was right. That line of thought somehow got me to thinking of Dr. Armstrong, who always seemed to do the right thing.

"You have to be working on the psychology of patients all the time," he had said to me one day as we were leaving the hospital. "If there's one man on this earth who has to have confidence in himself and make others feel it, it's the doctor. If a patient looks at you quizzically and wonders whether you know what you're talking about you can't do anything for him. Confidence and bread pills are worth ten times as much as tons of medicine without confidence. That's where Christian Science has it all over us.'

"You mean the Christian Scientist takes spiritual

medicine instead of material medicine?" I asked.
"Exactly," he went on. "In many cases it isn't what the patient gets, but what he thinks he gets that makes him well. I could do as much for any patient as Christian Science, if the patient had as much confidence in me as he has in his God. Now take the matter of bread pills for example. Most people would call us fakers if they knew we used them. Any placebo by itself is a fake, as a matter of fact. But no doctor can get along without them and fifty per cent. of patients who take them are cured.

"But we'll discuss these subjects some other time; what I want to get at is the necessity for a doctor to impress his patients by his assured manner that he knows what he knows when he knows it. Damn

hard thing to do, sometimes.

"I'll show you what I mean," he went on laughingly. "I've got six private patients upstairs, every-one of whom is seriously ill. I've worried about them considerably and I've wondered when I've been alone at night what the outcome was going to be with one or two of them. When I go into their rooms, if I dared show my anxiety they'd notice it in a minute and I expect it would be all up with them. Now each one of these patients has at least a dozen relatives hanging round the hospital day or night. They are on edge. They're looking for trouble. The temperatures don't go down to suit them. They keep sneaking into the nurse's room to read the charts. Some of them have pencils and paper and spend hours a day writing down questions to ask me when I come. 'Doesn't she look badly today?' 'Why did the temperature go up?' Why is the pulse more rapid?' 'Why did she have such a restless night?' 'Isn't it terrible she can't take milk?' 'When are her bowels going to work?' That's only a few of them. From the minute I leave this hospital one day until I jump out here at the door the next day, I am asking myself questions and answering them so that I won't slip up. And then there's that awful question, 'Doctor, are you sure she is going to get well?'"

I laughed at the way he put it.
"Laugh now, my boy," he said severely. won't laugh when it happens to you. Now here's the point I want to impress on you. No matter how tired I am, no matter how my nerves jump, no matter what aggravations I have had earlier in the day, by the time I reach the patient's bedside I have a quiet, confident, happy smile on my face. I make that patient feel the confidence I have in myself. I transfer a certain part of myself to him, until he gets enough of me to make him feel that he is going to get well. I've often heard a patient say, 'All I've got to do is to see your face, doctor, and I know I am going to get well.' Then I go outside and go through a third degree of questions, asked and implied. I brace my shoulders, keep the smile on my face somehow, although my spirit is in agony, and I feel like telling them to 'go to' and answer father, mother, sister, brother. My whole being radiates confidence

and I win."

It seemed strange to think of all this so early in the morning, but perhaps it was because I felt that I had impressed Mr. and Mrs. Caldwell in somewhat

the same way.

A copy of the American Magazine happened to be on my desk so I picked it up and began to scan the Suddenly my attention was drawn to an article by Edward Mott Woolley about a successful young doctor. I was much amused at the recount of his experiences which might have been those of any young man. A subtitle, 'How to Get Good Fees," interested me very much. interested me very much.

-But I have treated thousands of patients for little or nothing, often with a viewpoint to their advertising value. Even in difficult surgical cases I never charge a fee for treating doctors themselves.

"One doctor whom I treated sent me subsequently a servant girl who was suffering with an internal abscess. This doctor remembered some of my medical papers on abscesses and knew that I had done a lot of research on this subject and spent many hours in the autopsy room and libraries. The case looked bad to me and very unprofitable. Most young octors would have turned it over to a free clinic, but I believed I could handle it and I wanted the experience. I operated and for three weeks I almost gave up my practice and remained with this patient, fighting for her life. I was fighting, too, for results, not money. I couldn't afford to let this patient die.

"The remarkable results I finally got in this case were described by another surgeon in a medical paper and helped me immensely later on. Without this experience I never should have dared to undertake an all-important case, almost identical pathologically.

This story taught me a great deal, chiefly that the practice of medicine is no longer an art but a business, and that the young doctor had to deliver the goods. I wondered whether my servant girl was going to have any complications and if I would have to camp by her bedside for three long weeks. I made up my mind I'd camp, if necessary.

The chief thing about it all was that I had seen my duty and had gone ahead. I had no visions of multimillionaire patients or of having the case written up in the medical journals. Nor did I care.

I had saved a life. I was mightily pleased with myself.

CHAPTER XI.

I was getting pretty much fed up living alone. eight months I had come back to an office and a bed, but it could hardly be called home. I needed someone to take the sombreness off the place. startled the furniture each morning with a dust-rag, but there were earmarks of house-wifely neglect apparent everywhere. One could write his name on the dust on the wooden mantel-piece and the win-

dows had a smeared, greasy look.

In my frequent journeys to Staten Island to see Evelyn and when Evelyn infrequently dropped in on me on her off days, we would talk over our prospective marriage. On this Saturday afternoon, Evelyn had taken lunch with me and then had come to the office to look things over in general and to scold me like the wife-who-was-to-be for not having the place slicked up.

"One of Mary's off days," I told her. "She was to have come here this morning but she never showed

"Look here, Ev," I said as I got behind her and put my arms around her neck. "There's no use talking. We've got to get married P. D. Q. and have a regular girl whom you can boss all you've a mind to."
"Have you got the thousand dollars in the bank?"
she asked mischievously.

"Nope, I ain't," I answered colloquically, and then dragged her over to the chair and down on my knee. "John Snaith," she admonished. "Behave yourself.

How am I ever going to finish my work if you act Besides the dust lady ain't supposed to like this? be 'sittin' on the doctor's lap.' Ain't it terruble?"

I didn't answer, but leaned forward and opened a

desk drawer from which I withdrew a nice, clean, yellow leather bank book.

"How much did you say you would sell yourself

for?" I asked laughingly.
"One thousand bucks," she replied promptly.
"Pretty cheap, aren't you? How much do I get off for cash?"

Evelyn looked at me questioningly. "How much you got?"

"If you could give me a twenty per cent. discount for cash, I could work it alright.'

"John Snaith," she cried excitedly as she grabbed the book. "Do you mean to tell me you have saved up eight hundred dollars and never told me a word

about it?"

"Per-zactly. Now what do you think of your sweetheart? I've scrimped and saved and starved-don't I look it !- until I didn't think I'd last. I've bought sweet caporals instead of Moguls. I've smoked Prince Albert instead of Dunhill's 965. I've eaten beefsteak without onions and have gotten down to sinkers for breakfast. Don't you think I'm some martyr?"

"You're a dear-that's all."

"Ev, don't you think you could marry me on eight hundred?"

she answered. "You must have a thousand "No." in the bank. You think you could save the extra two hundred in the next four months?

"I'm sure I could, but I don't want to wait that

long. I want to get married right away. "Well, as long as you are sure you could, I suppose I'll have to help you. Four months longer of happiness together is worth more than two hundred dollars, isn't it? I'd like to give you the discount, John dear, but I simply can't. I'm a woman. But—"

"But what?"

"I'll loan you the two hundred dollars at six per

cent. interest for four months.

There's no use going into details of the next five minutes. But when they were over Evelyn made me cut a slip of paper four by eight inches and write thereon:

New York, Sept. 6, 1909. Four months after date I promise to pay to the order of Evelyn Snaith (she took it for granted that I would marry her after I got the money) the sum of two hundred dollars with six per cent. interest per annum. John Snaith.

Evelyn folded up the paper with a business-like, determined compression of her lips and took her check book out of her bag. A few moments later her check for two hundred dollars was in my desk.

'Thank you, partner. Not having any sealing wax to seal the official papers which ain't, how about sealing the transaction in another and equally satisfactory way?"
Evelyn stooped over and kissed me.

I was perfectly willing to be happy—but when I looked at Evelyn I changed my mind. Her face was screwed into knots and she was blubbering as hard as she would at her grandmother's funeral.

"For the land's sakes, what's the matter, darling?" I asked. I considered whether I had said anything to

hurt her.

"Nothing," she cried. "It isn't anything. I'm so happy, so happy, that—that—I can't help crying. Oh

John, I love you so."

Now if that wasn't just like a girl. Crying because she was so happy. I wanted to go out in the streets and yell. I wanted a quart of champagne. I wanted a Corona, Corona.

I looked over at her sitting there so small and sweet and pitiful—and all mine. Then suddenly a thought and pitiful—and all mine.

struck me.

"Come here!" I commanded. Evelyn looked up in surprise.

"Come here, I say. Come here this minute." She came.

I examined her ear lobes carefully.

"I thought so," I said. "Whatever has gotten into you, John?"

"I've been using my powers of observation. Once upon a time you wore ear rings."

"How did you know?"

"There's a fine little mark on the lobe of each ear. Ipso, facto-ear rings.'

She began to smile then.

"Wait until I have finished," I commanded. "Now let's see how smart you are. How many teeth has a dog? Does a horse bray or bark? Does a cow chew its cud at midnight? How many hairs have I lost off my head in the past six months?

By that time, Evelyn began to laugh and then I told her of the conversation Brownold and I had had. The upshot of it was that Evelyn was restored to

normal equilibrium.

I wanted to get married right away, that very afternoon-while I had the thousand dollars. But Evelyn

wouldn't hear of it.

We don't want an elaborate wedding, Boysy. But I wouldn't think of getting married without father and mother. And I must have a few clothes-a wedding dress, a new tailor-made suit, a new every-day hat, a few pairs of gloves, some new shoes and a new folderols which you don't need to know about-yet."

'A ll right, all right," I said peevishly. "It'll take you four months to get all those things, so you may as well take your money back."

"No, dear, it won't. I'll promise you now, that I shall be ready for you, hale, hearty and happy, four weeks from today."

We went over details. How many we should invite to the wedding, what sort of invitations we should send out, who was to do the catering, how we should furnish the apartment when we were together, in what rooms I could smoke my pipe and endless other details.

"We shall ask Dr. Armstrong?" she inquired. "Of course; I don't suppose he'll come, but I wouldn't leave him out for the world."

"How about Bill Franklin?"

I frowned. "Evelyn," I said soberly, "I'm worried about him. I can't make out what's the matter. I haven't heard from him very regularly and his last letter shows that things aren't going very well with him."

I reached over and took a letter out of the letter

file. "This came the other day," I said.

"Dear John:

"I ought not to write to-day because my head is as big as an elephant's and my eyes are bleary. But if I don't write you now, I don't know when I'll get at it again.

"I was glad to see from your letter that things are going swimmingly with you. Not so with me. I sit in my office all day long waiting for a patient to turn up. A stray, misguided one comes in once in a while and then I extract a two dollar bill. Five of them showed up last week, so I made ten dollars. In the interim, I daily smoke fifty cigarettes and eat up a bottle of booze.

"To tell you the truth, I'm disgusted with the practice of

a bottle of booze.

"To tell you the truth, I'm disgusted with the practice of medicine. I spent ten years of my precious life learning how to care for people and since then I've spent a million years waiting for people to take care of. But they didn't come. I wish to God I had learned something else.

"I've made loads of friends since I came here who let me play poker with them, dance with them, dine with them, wine with them. They wish me all the good luck in the world, but they don't come near me professionally.

"I don't see how I'm going to make a go of it here. In the past eight months, I've spent two hundred dollars more than I've made. Some of my expenses I've made up out of poker winnings. I'm a better gambler than a doctor and haven't spent nearly as much time in learning the former game. I'm disgusted clear through.

"I hate to ask you for money, old man, but if you find a fifty dollar bill lying around loose, just send it to me.

"Shakily,

When I had finished reading it, Evelyn said:

"I know what's the matter."
"What?" I asked, although I knew what the answer

"Too much drink for one thing. Poor Bill, it's a shame.

"I'm afraid you're right," I replied, solemnly "It's a shame. Bill's one of the finest fellows made and he's just going to the dogs. He always did drink a little. That's a fine crowd he's got into. I wish we could do something to help him."

"There's one thing you won't do, John. You won't send him that fifty dollars. It would be throwing good money after bad. I think you ought to write him a letter full of fatherly advice, and tell him what a mis-

take he is making."

"You are wrong there, Evelyn, dear. He'd appreciate money, but he wouldn't appreciate advice in his present state of mind. If I could see Bill here, for instance, I might possibly be able to read the riot act to him and enable him to see the error of his ways. Bill had a promising future before him, but he lacked one thing.

"What was that?" Evelyn asked.

"The inspiration and incentive fostered by the love of a pure sweet girl like you."

Evelyn blushed.

"I mean it seriously, dear. There are many men like Loveable, likeable, handsome, bright and clean, too. They have ordinary will-power but no more. They are so gentle minded that they are willing to do anything the other fellow asks them to do. They stay straight as long as the other fellow doesn't ask them to go wrong. They never see that they are going wrong until a girl steps in. If she's the right kind, she can mould him and make a real man of him. If Bill had a girl, he'd stop drinking and gambling and settle down to work."

'Let's ask him to the wedding, John. Beatrice Morgan will be there. Perhaps they will get together again. Write him that you'll advance him the money to come

So it was settled that Bill was to come to the wedding. He was to be my best man.

(To be continued)

Congress on Internal Medicine.

The Baltimore Session of The American Congress on Inter-nal Medicine was most successful. The following officers were elected to serve for 1921-22:

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FOR THE AMERICAN CONGRESS OF INTERNAL MEDICINE.
President—Dr. Sydney R. Miller, Baltimore, Md., Assistant
Professor of Medicine, The Johns Hopkins University.
Vice-President—Dr. Ellsworth S. Smith, St. Louis, Mo., Professor of Medicine, Washington University.
Second Vice-President—Dr. James Rae Arneill, Denver,
Colo., Professor of Clinical Medicine, University of Colorado.
Secretary-General—Dr. Frank Smithies, Chicago, Illinois,
Associate Professor of Medicine, University of Illinois,
Treasurer—Dr. Clement R. Jones, Pittsburgh, Pa., Lecturer

Treasurer—Dr. Clement R. Jones, Pittsburgh, Pa., Lecturer in Medicine, University of Pittsburgh.

FOR THE AMERICAN COLLEGE OF PHYSICIANS.

President—Dr. James M. Anders, Philadelphia, Pa., Professor of Clinical Medicine, Graduate School, University of Pennsylvania. sylvania

Vice-President—Dr. Frederick Tice, Chicago, Illinois, Pro-fessor of Medicine, University of Illinois. Second Vice-President—Dr. C. C. Bass, New Orleans, La. (Provisional, Professor of Research Medicine, Tulane Uni-

versity.
Secretary-General—Dr. Frank Smithies, Chicago, Illinois, Associate Professor of Medicine, University of Illinois.
Associate Secretary-General—Dr. Joseph H. Byrne, New York City, N. Y. (Provisional).
Treasurer—Dr. Clement R. Jones, Pittsburgh, Pa., Lecturer in Medicine, University of Pittsburgh.

Diagnosis and Treatment

Arhythmia in Reference to Diphtheria.

Farr says auricular flutter, one of the rarer forms of arhythmia, is characterized by extremely rapid (300-550) though regular contractions of the auricles which are registered by the electrocardiograph. It is one of the causes of paroxysmal tachycardia. Frequently the ventricles contract at a much slower, but regular rate, due to a condition of partial heart block. In other instances auricular fibrillation is simulated. Hume reports one case of paroxysmal tachycardia associated with auricular flutter occurring in diphtheria. In this case recovery followed.

Bradycardia and tachycardia may be due to multiple causes as above indicated. Bradycardia is more common in diphtheria than in other infections, though sometimes observed in meningits, in the convalescence from typhoid, etc. If extreme, below 40, it is usually due to partial or complete heart block; if moderate, below 60, it may represent a vagus effect. In the case of heart block failing definite lesions there is probably a functional interference with the conduction fibers; in the sinus type the myocardium is probably not a factor, rather there is an increased irritability of the vagus or a depression of the

sympathetic may be assumed.

Rapid heart is also common in diphtheria. Ordinarily it is attributable to toxic or other effects on the controlling nervous mechanism; in occasional and rare instances, to paroxysmal tachycardia or auricular flutter. Gallop rhythm, so often noted in toxic cases, is an auscultatory finding, dependent on a third cardiac sound, presystolic or protodiastolic. It has no necessary

relation to the true arhythmias.

In many cases as above noted there are compound arhythmias, heart block combined with sinus arhythmia, with extrasystoles or with fibrillation.

In a study of irregularities a distinction must always be maintained between mere pulse observation to which many old names refer and observations based on a study of the heart beat, venous pulse and arterial pulse. Thus an apparently in-termittent pulse may be due to totally different causes, sinus arhythmia, extrasystoles or heart block.

The cardiac complications of diphtheria, with which the pulse irregularities we have been considering are associated, chiefly concern the myocardium, almost never the endocardium. The diphtheria poison has a peculiar affinity for the heart muscle, the extrinsic and intrinsic cardiac nerves and the blood vessels (hyaline degeneration, thrombosis and embolism). Like other toxins it is also prone to cause paralysis of the vasomotor cen-

ter.

Cardiovascular symptoms in diphtheria occur principally at two periods: "Early," that is at the end of the first fortnight at a time when the local lesions (membranes, etc.) are clearing the conscident with or just preceding palsies; up, and frequently coincident with or just preceding palsies; "late," in the midst of convalescence (third or fourth week or even later). Almost all authorities (Rohmer) are agreed that myocarditis (parenchymatous, fatty and hyaline degeneration, round cell infiltration, etc.) is one of the chief, if not the chief (Hecht) cause of the circulatory manifestations, both early and late.

Most authorities, following Romberg, consider toxic vaso-motor disturbance to be an important or even the principal factor in early deaths. Until recently Charcot's (quoted by Rohmer) conception of vagus injury with resulting respiratory, abdominal and circulatory symptoms as an explanation of late cases, held a similar position. Some if not all of the cases included under this latter head may now be more satisfactorily explained by the assumption of functional or organic lesions of the conducting media in the heart side by side with the more diffuse myocardial changes. As we have seen, this explains the sudden fall of the pulse in several reported cases.—Penn. Med. Jour., Aug., 1920.)

Gonorrheal Stomatitis.

Chevelle and Georgel report in Revue Trimestrielle Belge de Stomatologie, June. 1919, the case of a young man who developed, some time after cure of a urethral gonorrhea, an intense gingivitis, which was assumed to be of gonorrheal origin although there is no mention of the presence of cocci in the secretions and no history of exposure of any kind. The fact that the affection yielded to anti-meningococcus serum injected into the buttocks may perhaps be regarded as evidence that into the buttocks may perhaps be regarded as evidence that the condition was of gonorrheal origin, as this remedy is used with benefit by the authors in complicated forms of gonorrhea. The lesions consisted of an intense tumefaction of the gum corresponding to the 6 anterior teeth of the lower jaw. Most of the area was covered with a greyish deposit suggesting sphacelation and the odor of the breath was fetid. Pus collected at the margin of the gum, and salivation was present.

Benzyl Benzoate in Circulatory Conditions.

D. I. Macht has found few cases of high blood pressure in which that condition was not relieved, at least temporarily, by benzyl benzoate. Most of the cases treated with the drug were ambulant patients who attended to their daily occupations while

ambulant patients who attended to their daily occupations while taking the drug while all the other conditions were the same. The only difference being the taking of benzyl benzoate, the effect of the drug in reducing the blood pressure was indisputable. In most of the patients the reduction of the blood pressure was accompanied by an improvement in their general condition. Thus, patients who complained of precordial pain or oppression showed decided improvement in that respect.

The most convenient and effective form of administration of the drug was found by the author to be the one originally used in his earlier experiments. A twenty per cent alcoholic solution of benzyl benzoate was administered by mouth, either in cold water or milk. The ordinary dose was found to be twenty or thirty drops of such a solution, taken three or four times a day. The administration of benzyl benzoate in the form of a solution was found to be especially useful because it allowed of a convenient reduction of the dose whenever desirable. He has found that after administering to a patient full doses of benzyl benzoate and obtaining a desirable therafull doses of benzyl benzoate and obtaining a desirable thera-peutic effect, the reduced pressure could be maintained by keeping a patient on very small doses of the drug, sometimes no more than five minims of the twenty per cent, solution.

The effect of benzyl benzoate on the blood pressure was dem-

onstrable even in such cases in which nitrites failed to produce a vasodilatation. Thus, Macht has been able to reduce a high blood pressure in patients who have become habituated to nitroglycerin and sodium nitrite. The onset of the benzyl effect, however, is not as rapid as in the case of nitrites, although sometimes the vasodilator effect was appreciable within thirty minutes. The duration of the benzyl effect, on the other hand, was much longer than that in the case of the nitrites, with the possible exception of erythrol tetranitrate. The blood pressure sometimes remained at a low level for several days after discontinuing the drug.

In his experience no toxic effects have been noted after ad-

In his experience no toxic effects have been noted after administration of benzyl benzoate by mouth. The drug has been given to some patients repeatedly for periods of over a year or more, without producing any untoward symptoms. So far as he has been able to ascertain from examinations of urine and functional tests of the kidneys, benzyl benzoate does no harm to the latter organs, and may therefore be administered, if desired, to patients suffering from nephritis.

As in the case of nitrites, however, he has noted, after observations extending over a period of more than two years, that patients will become habituated to benzyl benzoate and will not react as promotly to it as at the beginning of the

will not react as promptly to it as at the beginning of the treatment. Such patients, however, were generally of the nephritic type, whose condition was expected to become aggravated in the course of time.

vated in the course of time.

While benzyl benzoate acts as a vasodilator and will therefore reduce excessively high blood pressure, the indications for its clinical use are precisely the same as for the use of other vasodilators, such as the nitrites. Its action is a purely symptomatic one, that is, in reducing the blood pressure. It is of course well known that a reduction of the blood pressure in many cases of renal disease and other conditions is not indicated and may even be harmful. In such cases, of course, benzyl benzoate is not to be used any more than nitroglycerin or sodium nitrite.—(N. Y. Med. Jour., Aug. 28, 1920.)

Eucalyptus in Diabetes.

Peyre, in Le Nouveau Journal des Medicins, for December Peyre, in Le Nouveau Journal des Medicins, for December 20, 1920, refers to a case of diabetes mellitus in which eucalyptus was used partly for sore throat and partly as a tentative general measure after the ordinary methods of antidiabetic treatment had failed. The eucalyptus treatment consisted simply in drinking a small cupful of a decoction of eucalyptus leaves every evening two hours after supper and also occasionally in the morning.—Therapeutic Digest.

Recurrence of Chorea Warded Off by Cimicifuga.

In view of the fact that cimicifuga has a decided influence upon the generative organs, we can easily see the reason for the remarkable action of cimicifuga in cases of chorea occur-ring about the age of puberty. There can be no question about this; as I have seen such choreic movements and choreic seizures relieved at once upon the administration of cimicituga. This same, I found in many cases in which choreic seizures were dependent upon irregularities of uterine and ovarian func-It is well to remember that cases of chorea in which endocarditis or rheumatic infections play an important part will require other drugs in conjunction with the chorea remedies.—Dr. T. D. Adlerman in Therapeutic Digest.

Surgery

The Treatment of Bronchial Fistulae.

Carl Eggers reaches these conclusions:

1. Broncho-pleural fistulæ usually close spontaneously.

2. In the few cases in whom a fistula is responsible for the

persistence of a chronic empyema, treatment favoring the ob-iteration of that cavity will result in a closure of the bronchus. 3. Broncho-cutaneous fistulæ must be carefully studied and their ctiology and the present condition of the lung taken into consideration.

4. As long as the fistula acts as a safety valve for intrapul-monary suppuration, it must not be interfered with. 5. Mobilization of the lung and fistula, allowing it to recede

from its fixed position, is the most important factor in bringing about closure.

6. Muscle flaps are very valuable to cover the bronchial sinus after the necessary preparation has taken place. They aid in the closure and obviate deformity.

7. Cauterization of the fistula should always be done very lightly, to simply destroy the epithelium, never so deep as to produce a slough.

In case the wound is clean, suture of the bronchus should be done.

9. In cases due to lung abscess, in which it is feared that closure of the bronchus may result in damming back of secretions with the danger of pneumonia, the bronchus should not be sutured, but a muscle flap simply laid over it, placing a drainage tube at some distance to act as a safety valve.

10. Whenever possible the operation should be done under local anæsthesia.—(Annals Surg., Sept., 1920.)

Abscess of the Lung.

In 770 consecutive cases of pneumococcus lobar pneumonia admitted to the Rockefeller Hospital, John A. Hartwell says only 2 developed lung abscess, and each of these showed other infecting organisms. One of them completely recovered from infecting organisms. One of them completely recovered from the lesion in the lobe first involved, and later the abscess containing no pneumococci formed in the other lung, in a part where the evidence of lobar pneumonia was very recent and scant. In this series there were two others showing a pneumococcus infection, but the diagnosis of a lobar pneumonia could
not be substantiated by the physical signs or the radiograph.
During the same period there were 140 cases of broncho-pneumonia admitted, one of whom developed a lung abscess.
The entire number of abscesses observed in this hospital has
been 9, the remaining 6 being divided as follows: 2 followed
arrevious tonsillectomies with mived infections: 3 cocurred aris

previous tonsillectomies with mixed infections; I occurred primarily with a staphylococcus aureus infection; 2 occurred pri-marily with a very mixed bacterial infection, and I resulted as

marily with a very mixed bacterial intection, and I resulted as a late manifestation of a staphylococcus aureus pneumonia. Our studies lead to the conclusion that the staphylococcus aureus is an important agent in abscess formation.

Great interest attaches to the subject of the pathogenesis of the abscess. In this connection the recent studies of Cecil and Blake are important. These authors found in their studies of the pathogenesis of pneumonia and other pulmonary infections that the inflammation is the lung acceptume. that the inflammation in the lung parenchyma, following injec-

tions of virulent cultures into the trachea of monkeys, preceded by some hours the exudation in the air vesicles. Inasmuch as the infecting organisms must sooner or later invade and break down this interstitial tissue, if an abscess is to result, this very early invasion throws light on the occur-rence of a primary abscess, that is, pus formation before there is any pneumonic consolidation. In fact, in some cases, such consolidation may never appear. More often, however, the presence of a true consolidation may be demonstrated. The changes from this condition with the vesicular exudate and the interstitial inflammation to abscess formation are to some ex-tent elucidated by the study of the pneumonic lung, particularly when there exists a mixed bacterial flora.

Many cases of pneumonia coming to autopsy exhibit areas in which the interstitial spaces are packed with the products of the pneumonic inflammation, the vesicle walls are more or less the pneumonic inflammation, the vesicle walls are more or less destroyed, and the lung substance is converted into an acutely inflamed zone showing foci of necrosis. In many instances these foci have progressed to a farther stage and liquefaction is present, i. e., a beginning abscess (Figs. 1 and 2). The majority of such foci are very small, and while pathologically they are abscesses, this could not have been determined clinically. It is to be assumed that, had such cases survived, there would have occurred, in some, at least, a farther development and clinical evidence would have been present. Chickering and Park found in the lungs of patients dying from staphylococcus aureus pneumonia, multiple abscesses varying in size from a millimetre to a centimetre. The content varied from a necrotic

mass to a thick, greenish, yellow pus. In no instance was the abscess large enough to have given clinical signs.

All these studies emphasize the belief that lung abscess is a very important possibility much more often than is realized. We have no knowledge of how frequently these small focal abscesses form and undergo resolution and drainage, but this evidence is in favor of its frequent occurrence. We are not informed as to the causes which bring about their continued growth into large abscesses. One is compelled to fall back upon the unknown factor of resistance and virulence, with, in addition, the factor of a better or poorer drainage via the bronchioles. Study of the bacteriology yields the information already mentioned. Abscesses are encountered clinically, following all types of pneumonia, but the rule is to find a secondary invader, such as staphylococcus or streptococcus, occurring alone or in conjunction with the influenza bacillus. All these organisms have been found in the sputum of patients suffering from lung abscess. On the other hand, all types of lung infections regularly occur without the development of lung abscess. The clinical facts on which to base a belief that the ordinary pyogenic bacteria, particularly the staphylococcus aureus, are more prone than other organisms to produce a lung abscess are given above. It is to be emphasized that a staphylococcus aureus and well-marked abscess may occur almost with lococcus aureus infection may produce an abscess without a true pneumonia. A well-marked abscess may occur almost with the inception of this infection, and be fully developed within a few days of the onset of the illness. Such a lesion is the

a few days of the onset of the illness. Such a lesion is the primary lung abscess already mentioned.

There is, in every case of abscess, an exit for the fluid pus via the vesicles and small bronchioles. This drainage, however, is often inadequate, and following the law of all suppuration, the process extends along lines of least resistance. Abscess cavities, from five to ten centimetres in diameter, up to an entire lobe, may thus be formed. A fluid content of several hundred cubic centimetres is not uncommon. Ultimately, a larger bronchus is opened to it, drainage is free, and the complete pathological picture of the abscess is present. Often several large bronchial openings into the abscess are present. An abscess in the more superficial parts of the lung tends to reach a considerable size before it lies in relation to a bronchus of sufficient lumen to afford an avenue of adequate drainage.

reach a considerable size before it lies in relation to a bronchus of sufficient lumen to afford an avenue of adequate drainage. In the deeper parts, on the other hand, such bronchi are more numerous, and it is possible for drainage to be more complete (Figs. 3 and 4). This is an important fact from a therapeutic standpoint. It also has a most important bearing, as we believe, upon the occurrence of empyema and its occasional drainage through the lung and trachea.

heve, upon the occurrence of the property of the language through the lung and trachea.

When the abscess is fully established, as seen, for instance, at operation, its wall is a ragged surface of necrosing lung tissue around which, microscopically, are found cedema, leucocytes, dilated and thrombosed blood-vessels and bacteria, all of which pack the air vesicles as well as the interstitial space. Its outline is often irregular, giving the impression that several foci of suppuration have coalesced into one abscess. Between these diverticula the lung substance may be dead in considerabel areas. When the infecting organisms are unusually virulent a surrounding gangrenous condition may supervene. Putrefactive organisms gaining entrance from the mouth vene. Putrefactive organisms gaining entrance from the mouth to such areas produce a putrid mass. Such lesions are not uncommon, and should be designated as already discussed, as gangrenous abscess rather than lung gangrene.

Since, whatever the cause of the abscess, there exists an antecedent inflammation, the surrounding zone is always well

It is emphasized in abscesses secondary to the pneumarked. It is emphasized in abscesses secondary to the pneumonic infections, because such abscesses occur in portions where resolution has been incomplete and the interstitial inflammation is marked. In studying the physical signs of abscess formation and in reading radiographs, this zone must be given due consideration. It often acts as a very troublesome mask to a proper diagnosis.—(Annals Surg., Vol. LXXII,

Pedicle Graft Replacing Ablated Heel.

Dr. Nathan W. Green presented to the New York Surgical Society a laborer, forty-two years, who was admitted to St. Luke's Hospital on April 14, 1917. His complaint was a painful and tight cicatrix of the right heel with an ulcer on the under surface. This condition was from an injury sustained nine months previous to his admission. The injury was caused by a large paper roll which ran against his heel, removing the skin and cushion of the heel. He was at once taken to a hospital. The wound healed, but whenever he tried to use his foot it would break down and was very painful.

On April 23, 1917, the first stage in the operation for plastic repair was done by Doctor Green. On the sole of the foot a small granulating area was present, the whole right heel being covered with a thin cicatrix. The cicatrix was dissected Dr. Nathan W. Green presented to the New York Surgical

away from the heel down to the periosteum and ligaments and a large flap, comprising all tissues down to the muscle, was dissected up from the left thigh just above the knee. (This flap was made with its pedicle so placed that it might be elongated and applied to the heel at a subsequent sitting.) The right heel was brought into apposition with the flap which was sutured over the denuded area of the heel. A plaster case was applied from the waist down, holding the heel upon the

was applied from the waist down, holding the heel upon the opposite thigh.

Two weeks later, May 7, 1917, the second stage of the operation was performed. The flap that had been dissected up and applied to the heel was found to be healthy and growing. (Two weeks was thought to be sufficient time for the first part of the flap to have united.) The case around plastic juncture was removed. The flap on left thigh was dissected somewhat further and sutured over the denuded area of right heel with No. I chromic gut. The denuded area was now completely covered over except at one place. The plaster case was replaced.

Again, two weeks later, May 21, 1917, the third stage of the operation was performed. The case was removed and the flap found to be viable with practically no slough. The pedicle of the flap was cut loose from the left thigh and sutured to the right heel at the only remaining free point. The wound on the thigh was closed partially and small Thiersch grafts were placed upon the granulating area. The heel was dressed with dry dressing.

The patient was discharged July 6, 1917, with the following note: "Inner side of flap has united perfectly. A small sulcus persists on outer side of heel, which, however, is lined with epithelium" and is "entirely healed." "Motion is somewhat restricted, but improving."

The patient was absent from the hospital for one and three-quarter years and had been working. On account of a small pressure sore on his heel he was readmitted April 14, 1919.

On readmission on the plantar surface of graft was an area of induration about 2 cm. in diameter. In the center of this area there was a small ulceration.

or induration about 2 cm. in diameter. In the center of this area there was a small ulceration.

On April 16, 1919 (one and three-quarter years later), a small operation was performed, excising the scar tissue and ulcer, between the os calcis and the heel of the shoe. There ulcer, between the os calcis and the heel of the shoe. There was then an ulcerated area of scar tissue about the size of a half dollar. A circular incision was made about the scar tissue. The tissue was dissected free and excised. A small area of the scar tissue deep in the subcutaneous tissue was dissected free and excised. The wound was closed with interrupted sutures of chromic gut. Dry dressing was applied. He was discharged May 9, 1919, improved and is now, March 24, 1920,

Surgical Treatment of Abscess.

The study of A. W. Adson, Rochester, Minn., is a reiew of twenty-six cases of brain abscess examined at the Mayo Clinic during the last five years; the diagnosis in twenty-three instances was verified either by operation or by necropsy. For the purpose of detailed study of twenty-six cases are divided into two groups, nonsurgical and surgical cases. Of the seventeen patients who were not operated on, seven died shortly after admission or during the time of observation. Seven had been operated on previously for chronic empyema or lung abbeen operated on previously for chronic empyema or lung abscess, or they presented symptoms of bronchicctasis or chronic tuberculosis; five of the seven died; necropsies were performed on four here; one patient died at home. Two patients recovered (the latter are necessarily uncertified cases). Three patients died following a radical mastoid operation for chronic otitis media with subdural abscess. They belonged to a group of thirty-six cases in which the radical mastoid operation was done for chronic otitis media associated with some form of subdural abscess. Nine of the twenty-six patients were operated on for brain abscess; five recovered, and four died shortly after the operation. Of the five patients who recovered, four are now living; one died two years following operation; the cause of death was not reported to us. The four principal etiologic factors were otitic infection, frontal sinusitis, injury to the skull, and hematogenous infection. The abscess was located in the frontal lobe in fourteen patients; in the temporal lobe in four patients; in two in the temporsphenoidal lobe; in one in the occipital lobe; in two in the cerebellar lobe; in one in the midbrain; in one under the temporal lobe, and in

lobe; in one in the occipital lobe; in two in the cerebellar lobe; in one in the midbrain; in one under the temporal lobe, and in one on the cortex, associated with encepthalitis.

Thirteen patients complained of headache, ten of nausea or projective vomiting, four of blindness, twelve of jacksonian epilepsy, four of grand mal epilepsy, fourteen of naralysis sixteen of habitude or coma, two of injury to the skull, nine of meningeal irritation, and ten of fever. A résumé of the findings reveals urinalysis usually negative, a slight leukocytosis, and if the abscess is unattended with meningitis or cortical encephalitis, a negative spinal puncture. One-third of the pa-

tients studied had choked discs, ranging from 1 to 7 diopters, one-third had local tenderness over the abscess, and one-half had a motor or mental impairment. Adson says that if the abscess has developed by contiguity, it should be explored through the area of infection; but if the abscess is remote from the source of infection, it should be explored and drained through an osteoplastic flap craniotomy. Surgical treatment is of little value in the initiatory or terminal stages, or in the presence of meningitis, but it is of great benefit during the quiescent stage. If there is doubt as to the differential diagnosis of brain tumor and brain abscess in the quiescent stage, it is advisable to explore rather than to perform a decomit is advisable to explore rather than to perform a decompression operation for intrachanial pressure or to wait for terminal symptoms.—(J. A. M. A.)

Syphilis

Further Progress in the Study of the Relative Efficiency of the Different Mercurial Preparations.

In the treatment of congenital syphilis in infants and children, as determined by a quantitative analysis of the mer-cury elimination in the urine, Mercurial ointment, 50 per cent., is to be preferred to the less concentrated forms and Ramsey A. Groebner. Calomel ointment is absorbed but less rapidly and to a less extent than the mercurial ointment. Salicylate of mercury in oil should be given hypodermically twice weekly. Mercurial chloride, by hypodermic injections, although the dose is very small, continues to be eliminated for six or seven days. The fact, however, that its use frequently is followed by the appearance of protein in the urine cherkle weekled.

quently is followed by the appearance of protein in the urine should exclude it from the treatment of syphilis in children. Calomel by the mouth is absorbed in small amounts, and continues to be climinated for a considerable time so that it is probable that it would be sufficient to give it at intervals of several days, thus avoiding diarrhea. Gray powder is absorbed to a small degree and eliminated rather rapidly so that large doses repeated daily would probably be necessary to maintain mercury in the circulation. Further experiments will be carried out to determine whether the clinical results will bear out these observations. In one case of congenital syphilis, treated by inunctions of 50 per cent., mercurial ointment, once weekly, the clinical progress was apparently quite as satisfactory as in cases where inunctions were given.—(Amer. Jour. Dis. Child., September, 1920.)

Absorption and Elimination of Mercury in the Different Methods Used in the Treatment of Syphilis.

In order to obtain the required saturation of the body more quickly, it is of advantage to make the supply of mer-cury somewhat larger at the beginning of the cure than afterwards, says Svend Lomholt. Amount of mercury conafterwards, says Svend Lomholt. Amount of mercury considered sufficient to cover the daily consumption (saturation and elimination) can be estimated at 6-10 mgrm per day according to the size and tolerance of the patient. The curves of elimination of the different methods of mercury treatment show that this can be obtained by inunctions, by small numerous injections of soluable compounds and by injection of calomel.—(Brit. Jour. Derma. and Syph., December, 1920.)

Some Salient Facts Regarding the Toxicity of Arsphenamin and Neoarsphenamin.

Geo. P. Roth, U. S. P. H. S. concludes: (1) Neoarsphenamin behaves differently in the animal organism from arsphenamin and should not be regarded simply as arsphenamin in a convenient form for administration. (2) When administered intravenosly and at a constant rate, acid solutions of arsphenamin are much more toxic than the cor-responding alkaline solutions, the toxicity of the acid soluresponding alkaline solutions, the toxicity of the acid solutions increasing with the concentration. (3) A properly alkalinized 2 per cent. arsphenamin solution when administered intravenously and in high dosage is slightly more toxic than an 0.5 per cent. solution. (4) The toxicity of properly alkalinized arsphenamin increases greatly as the rate of its intravenous administration is increased. Rate of administration is, therefore, an important factor in determining toxicity. (5) When neoarsphenamin is found to dissolve with comparative difficulty, it is generally highly toxic and should be discarded. (6) Shaking aqueous solutions of neoarsphenamin or alkalinized arsphenamin in the presence of air increases their toxicity markedly. When a 4 per cent. solution of neoarsphenamin is shaken vigorously for ten minutes its toxicity is more than quadrupled. (7) Arsphenamin preparations made in the United States compare favormin preparations made in the United States compare favorably, and in certain instances are decidedly less toxic than of the foreign products .- (Arch. Derm. and Syph., September, 1020.)

Rectal Injection of Massive Doses of Neo-Arsphenamin.

Believing that perhaps the clinical failures by the intrarectal method might be due to the fact that the doses were too small, H. G. Mehrtens, San Francisco, gradually increased the dose by rectum until 4 gm. of neo-arsphenamin was given. Intravenous injections were also given. The absorption and distribution were checked by determination of arsenic in the blood, urine and spinal fluid after each method of administration. For the rectal injection the patients were given a brisk purge on the day preceding the treatment. Two hours before the treatment they were given a colonic flush until the washings returned clear. Simultaneously with the injection, tincture of opium or paregoric was given by mouth, or, in some cases, morphin by hypodermic injection. The arsphenamin was dissolved and neutralized just as for intramorphin by hypodermic injection. The arsphenamin or neo-arsphenamin was dissolved and neutralized just as for intra-venous injection. The volume for each dose was 100 c.c. This was retained twenty-four hours, if possible. Frequent examina-tions of the blood revealed that the arsenic is absorbed into the blood after such injections, and larger quantities are elimi-nated in the urine than after ordinary intravenous injections of arsphenamin.

Arsenic persists longer in the blood in perceptible quantities after the rectal method with large doses than after ordinary intravenous methods. Mehrtens believes that, all things being equal, the intravenous method of administering arsphenamin and neo-arsphenamin is still the method of choice in most cases, but the rectal administration of neo-arsphenamin has a place in the rectal administration of neo-arsphenamin has a place in therapy when massive doses are used, especially in the cases of children, those with difficult or impossible veins, and in the case of those in whom, for any reason, intravenous injections are dangerous or undesirale.—(J. A. M. A.)

Skin Diseases and Syphilis in 1920.

In the course of this long review, H. Gougerot remarks that there seems to be increasing agreement as to the wisdom of large progressive doses in primary syphilis. Milian gives from large progressive doses in primary sypniis. Maina gives from 0.3 to 0.9 gm. or even 1.2 of neoarsphenamine in the primary phase. Leredde in the second and third phases begins with small doses, 0.1, increasing to 0.9. With syphilitic disease in the nervous system, kidneys or aorta, the doses recommended are between 0.1 and 0.3. The advantage of associating merare between 0.1 and 0.3. The advantage of associating mercury with the arsenicals is admitted more and more. "The arsenical attacks, but the mercury brings up the reinforcements to hold what has been gained." As to mishaps with the arsenhenamines, Gougerot thinks that damage of the organ by the drug and damage by syphilis both co-operate. Abadie declares that in rebellious cases treatment should be kept up with mercuric cavaids by the value are arranged by the value of the organ by the drug and damage by syphilis both co-operate. gm. for one, two or three years if necessary, and reports success beyond all hopes in certain cases by this means. Gourgerot presents the arguments for and against there being more than one type of spirochete, inclining to the negative view himself.—

(Médecine, Paris, November, 1920.)

Serodiagnosis of Syphilis.

P. L. Marie passes in review the various methods of the serodiagnosis of syphilis proposed in recent years, adding that Vernes' researches have demonstrated the general nature of the phenomenon of the flaking of suspensions of colloids under the influence of serums syphilitic or not. But syphilitic serum induces it a little faster than normal serum. It is merely a question of degree in a general physical-chemical phenomenon. This flaking is not pronounced enough to be visible, but it becomes visible indirectly by the inhibition of hemolysis, which it entails. Vernes' latest reaction is based on the super-flaking properties of syphilitic serums, as estimated with a standard opalescence scale. Marie remarks in conclusion that it is searcely probable that Marie remarks in conclusion that it is scarcely probable that syphilis is the one disease that induces physical-chemical changes in the serum, and evidence is accumulating that the serum in tuberculosis and cancer may have a special action on suspension of colloids.—(Presse Médicale Paris, Nov. 29, 1020.)

Colloidal Gold Test in the Cerebro-Spinal Fluid in Secondary Syphilis.

One thousand new observations confirm 750 former tests. Kyrle. Brandt and Mras maintain that a strongly positive colloidal gold reaction is of considerable prognostic importance in secondary syphilis, as it shows that the infection of the spinal fluid has not yet cleared up, and that exacerbations of the disease may occur.—(Wien. Klin Woch., August 19, 1920.)

The Medical Times

A MONTHLY JOURNAL

OF

Medicine, Surgery, and the Collateral Sciences
ESTABLISHED IN 1872

H. SHERIDAN BAKETEL, A.M., M.D., F.A.C.P.

ARTRUR C. JACOBSON, M.D. Associate Editor.

Contributions.—EXCLUSIVE PUBLICATION: Articles are accepted for publication on condition that they are contributed solely to this publication.

When authors furnish drawings or photographs, the publishers will have half tones and line cuts made without expense to the writera.

SUBSCRIPTION RATES: (STRICTLY IN ADVANCE)

UNITED STATES (Liba, Mexico, Porto Rico, Hawalian and Philippine Islands)

Definite written orders for THE MEDICAL TIMES are required from all subscribers, to whom the journal is thereafter regularly forwarded. Notify publisher promptly of change of address or if paper is not

Remitted regularly.

Remitted for subscriptions will not be acknowledged, but dating on the wrapper will be changed on the first issue possible after receip of same.

All communications should be addressed to and all checks made payable to the publishers.

MEDICAL TIMES CO.

ROMAINE PIERSON, President and Treasures H. SHERIDAN BAKETEL, Secretary

95 Nassau Street,

New York

NEW YORK, APRIL, 1921

Healthful Life Versus Art

Much is being said by pessimistic critics about the shortcomings of American life, and a favorite method of attack is to point out the failure of the country to produce great books, paintings, musical compositions, and other works of art. Mr. James M. Beck, for example, the distinguished jurisconsult, has reproached the city of New York for its numerous theatres with their vast box office receipts and their paucity of great drama, reminding us of the masterpieces first produced in old inn-yards and later in such primitive Elizabethan theatres as Shakespeare's Globe. Mr. Frank Harris also insists that we have "no art, no literature and little science," and sees no occasion for excitement or self-congratu-lation in the United States over the production of "Main Street," or the work of Edgar Lee Masters, or Robert Frost, or any of the other names on the lists of American publishers. "There was once more interest in art," continues Harris, "but now you read no books, you buy no pictures. You go somewhere in the flivver. Henry Ford has done you more harm by his great production of machines than any writer will ever do you good. The United States appears wholly abandoned to the pursuit of the production of wealth.

Now we dare to submit that it is a more wholesome thing to live gloriously than to write or read books, paint or view pictures, or compose or listen to sonatas, for these things merely mirror or interpret life itself. Much of our art is but a pale reflection of, or substitute for, life. Life is the thing, realized by actually living. Art offers a means of escape from life. It is a greater and more glorious thing, said Goethe, for a woman to bear and care for a baby than to write the most remarkable

The people who would be writing great books or painting masterpieces, were they artists, are, nowadays, interested instead in the fine art of living, and are very ably expressing themselves, in large part on public platforms. We notice that even Messrs. Beck and Harris are doing their share of that sort of thing. If Shakespeare had had a lyceum circuit to go out on he would have written fewer dramas (we could spare some of his bad ones). A public character, in giving a sketch of his life in the British Who's Who, significantly names as his exercise public speaking, which is not practised as an art, but as a means of oxidation and elimination.

Jesus wrote nothing, and painted nothing, but His life was beyond all epics. Which would you rather have, companionship with the Nazarene or a gospel screed to read? Who would not rather have heard the Sermon on the Mount, spoken naturally by Jesus, than to have read it in the pages of Luke, the literary artist?

Sickly, temperamental people, without much esthetic power, are the ones who talk most about art. We submit that it would be much healthier for their souls and minds to view the countryside in a flivver, and much healthier even to crank the latter, than to write odes to an owl and sonnets on sin.

Busy Americans, tiring themselves healthily, and wearing out instead of rusting out, are a more wholesome lot, in the mass, than the whole tribe of poets. They ought to abandon their defensive rôle when these matters are broached.

It has been charged against the Pilgrim Fathers that they possessed no esthetic inclinations, but their high adventure in living puts to the blush all the devotees of art. They were indeed esthetes in that they were in love with dynamic life.

Not to be afraid of life is better than to crystallize cross-sectional phases of it upon a canvas. The supreme artist, God, has given us sunsets enough and the nightingale's song and the spectacle of youth and the perfection of human form in profusion. The man who appreciates these cannot be said not to possess the esthetic temperament, which is by no means the sole possession of professed artists of brush and pen.

True, the artist has a legitimate function. It is to awaken the dead amongst us to the beauties of life. He is a sanitarian in the best sense, making for the health of the soul and consequently of the body as well. But we who are alive and in love with life are in no dire need of his ministrations. Our failure to prefer essays to assays proves nothing sinister against us.

America is a great body instinct with glorious life, and that is enough. No indictment really attaches to us for our failure to produce great art. Does not this failure simply mean that we are not decadent? We are young, vigorous, healthy and wholesome, wherefore there can be no Juvenals or Swifts.

Kipling once presented a set of his works, illustrated by Zogbaum, to Admiral "Fighting Bob" Evans, of the United States Navy. The lines which Kipling inscribed on this occasion seem to us apropos:

Zogbaum draws with a pencil,
And I do things with a pen,
But you sit up in a conning tower
Bossing eight hundred men.
To him who hath shall be given
And that's why these books are sent,
To the man who has lived more stories
Than Zogbaum or I can invent.

Strange Roads Lead to the Temple of Healing Speaking about the Rockefeller Foundation, the Federal Industrial Relations Commission says that "The money with which the Rockefeller Foundation was

created and is maintained consists of the wages of workers in American industries. These wages are withheld by means of economic pressure, violation of law, cunning and disorder, practised over a series of years by the founder and certain of his business associates.

Life is certainly paradoxical. There is nothing logical about it. Here we have able and kindly men effecting, under the auspices of the Foundation, the most beneficent of medical results, and yet they owe their opportunities to sources of wealth that were at one time rooted in human misery of the most dreadful character.

Men are first exploited outrageously, and then, upon the colossal funds accumulated thereby, scientists are set to work to make the lot of humanity more tolerable. First appears the sinister Captain of Industry, then

the superscientist Jacques Loeb or some wizard of the medical research laboratory. The industrial bludgeon, matted with the blood and tears of the wretched workers, gives place to the vial of healing serum.

How strange the social order that knows no other road to its goal than this!

The Psychoanalysis Craze

The Journal of the American Medical Association of January 29 had the following to say on the subject of the psychoanalysis craze:

Recently the minister of a prominent church in Chicago was asked by the head of the social work department to put his approval on the establishment of a lecture course on psychanapproval on the establishment of a lecture course on psychan-alysis. Being in doubt, he conferred with several medical men of his congregation. Finally a neurologist settled the matter by saying: "By all means have it. It should prove very popu-lar. Half the congregation is already crazy and the other half is en route to the asylum." The jest was not wholly a jest. People are paying too much attention nowadays to their minds. An abnormal interest in the workings of one's own mind pro-duces either an introspective philosopher or a "common nut." An abnormal interest in the workings of one's own duces either an introspective philosopher or a "common nut."

When the interest is related more or less distinctly to a concealed but nevertheless obvious fascination for cogitation on its has elements of danger. Physicians are bethings sexual, it has elements of danger. Physicians are beginning to wonder where the normal interest of the layman in these subjects ends and the scope of the psychiatrist commences. We are flooded with books on the subject by lay psychanalysts; the "movies" picture it; the theaters dramatize it; the churches have lectures on it. In the not too distant future this psychanalytic craze, if it continues, will make the medical psychiatrist a very busy man.

A fool is a fool, whether he resorts to psychanalytic treatment or not. Psychanalysis is merely an addition to our systems for revealing fools. It supplements new

to our systems for revealing fools. It supplements new thought, osteopathy, spiritualism and the rest of the pre-vailing folderol. The medical psychiatrist is destined to be a very busy man, even if there were no psychanalysis. The fool supply is unlimited. Psychanalysis will not make fools of those who are already fools, but only reveal them, and to this extent, as we have said, it will prove a useful supplement to more rough and ready means of revelation. It cannot make fools of those who are not fools-nothing can do that.

Pessimism or Truth?

Certain recent deliverances of a distinguished, informed and wise authority upon matters of sex have set us wondering whether the drab picture drawn by him betrays a distorted perspective or whether it reveals the simple truth.

This gentleman believes that the race is sexually decadent, and he submits a list of shortcomings which seemingly goes far in justifying an indictment for lessened virility. His argument has a plausibility about it that rather discourages effective reply.

It is pointed out that the present-day male is a masturbating, premature-ejaculating, withdrawing, condomusing, monogamous creature in the mass, that he can easily be persuaded to practise continence, that sexual indifference can be readily acquired by him, that he considers an indulgence of once or twice a week quite a normal record (we don't know the critic's standard), that he reveals a suspicious facileness in sublimating his sexual powers along lines of pickle manufacturing or real estate manipulation (practising medicine?), and finally that he attains sexual senescence prematurely.

The implication is, of course, that man has become a sexual weakling, compared with his virile progenitors.

Is the indictment well drawn? Is civilization sapping our manhood, as well as costing us dear in a hundred other ways? Is emasculation the price of what goes by the name of success in the modern world?

It has been prophesied that man is to become a hairless and toothless creature, with greatly impaired powers of locomotion. Perhaps to this decrepitude will be added relative impotence.

We apologize for the cheerlessness of the foregoing remarks, but are the facts as stated, and is the reasoning

Miscellany

CONDUCTED BY ARTHUR C. JACOBSON, M. D.

Interesting Item from the "Medical Record" of

Feb. 19. I am informed on good authority that one dealer at least who has made a fortune by the illicit sale of liquor and who was anxious to retire with his gains before he was caught, is was anxious to retire with his gains before he was caught, is prevented from doing so by those from whom he obtains his supplies. All attempts on his part to close out his business are frustrated by those from whom he obtained his wares by their constant renewal of his stock despite his efforts to restrain them. Who these purveyors are is not difficult to imagine. The current news of the day will afford a clue to their identity. identity.

Chiropractic Magic

Special Dispatch to The New York Hera'd.

CHICAGO, Feb. 14.—"Oh, I almost forgot! To-day is St. Valentine's Day. I must send my teacher and my school friends valentines."

These were the first words uttered by eight-year-old Miriam Rubin, the talking girl of Waukegan, when she roused herself to-day from the first real sleep she has had in nine days. When her mother brought the box of valentines which the little girl had purchased just before her illness, Miriam gave to her mother the names of her school teacher and classmates to the set.

As Dr. Paul Berger of Waukegan, after he had snapped back into place the vertebrae which he believes were the cause of the trouble, was saying goodby to the Rubin family, Miriam interrupted: "Now, doctor, you can go and break somebody clse's neck." Within two weeks little Miriam will be restored to normal health, Dr. Berger stated.

to normal health, Dr. Berger stated.

Constant treatments for two weeks will be necessary to keep the vertebrae in natural alignment and carry Miriam safely through the present critical period. The delicate segments of the child's spinal column, which Dr. Berger restored to their proper place Sunday night, had been pulled out of alignment again to-day by the abnormal contraction of the muscles in the neck. Again the surgeon was obliged to manipulate these muscles, and by skilful pressure of the finger tips return the two dislocated vertebrae to normal.

The child's temperature has reached to near normal and her chatter was less incoherent to-day.

Light on the Chiropractor

According to the Chicago Tribune, the following chiropractic testimonial appeared in a Michigan publi-

"Dear Doctor.-Before taking your chiropractic and electric treatments, I was so nervous that NOBODY could sleep with me. After taking six treatments ANY-

BODY can sleep with me."

The J. A. M. A. of Feb. 5, 1921, quoting the foregoing, adds that it would be fatal for a chiropractor to have a sense of humor; in fact, if he had it, he never would have become a chiropractor.

\$300 IN PRIZES



What is the best title for this picture?

For the best title to the picture above The Medical Times will award prizes as follows:

| First Prize . | , | | | \$150.00 |
|---------------|---|--|--|----------|
| Second Prize | | | | \$100.00 |
| Third Prize | | | | \$50.00 |

The contest will be governed by the following RULES

By "best" is understood that title which most cleverly describes the situation shown in the picture.

No title submitted shall consist of more than ten words.

The contest is open to physicians, medical students, interns, nurses, and advertising patrons.

The contest is now open. It will close October 1, 1921. All titles should be addressed to The Contest Editor, of Medical Times, 95 Nassau Street, New York, N. Y. Envelopes should contain nothing but the competing title and the name and address of the sender, plainly written, all on the same sheet. Readers and subscribers to Medical Times are cautioned not to enclose checks or payment for old or new subscriptions, or changes of address, in correspondence for Contest Editor, as letters for the Contest will not be opened until October first.

Titles will be judged by three members of the MEDICAL TIMES Staff and their decision will be final.

In the event of two or more persons submitting the titles which are considered the best, second best or third best each will receive the prize offered.

Titles may be original or may be a quotation from some well-known author. Contestants may send in more than one title. The final award will be announced as early as possible after the close of the contest. Of this due notice will be given. Checks will be sent simultaneously with the announcements of the award,

The Medical Times Company 95 Nassau Street

Public Health

Public Health and the Submerged Classes.

That more than 75,000 men, women, and children out of a total population of 783,000 are dependents, delinquents, or feeble-minded and are unable either to work or fight and are feeble-minded and are unable either to work or fight and are a constant drain on the finances, health and morality of the State is the startling result brought out by a survey conducted in Oregon. Moreover, more than 500 school children out of a total school enrolled population of 32,500 were found to be more or less mentally deficient, a fact which is of much significance when it is remembered that the condition of the children of today is the best possible index to the condition of the community of tomorrow and indeed to the future of the race.

The figures yielded by the Oregon survey are considerably lower than the average shown by the draft examination, a fact that indicates, in the opinion of the U. S. Public Health Service officers, that they are certainly not higher than those that would be obtained by similar surveys in other States. It is considered greatly to Oregon's credit that it has been one of the first States to realize the importance of the problem and to take effective steps toward ascertaining the exact facts concerning it.

concerning it.

The survey was authorized by the Oregon legislature and was carried out by the University of Oregon in collaboration with Dr. C. L. Carlisle, of U. S. Public Health Service.

"The making of the survey," said Surgeon General H. S. Cumming, "was not an easy task, for in Oregon, as in many other States, comparatively few of the types involved are being cared for in institutions. The rest are widely scattered and were practically unknown, for most of them are quiet and do not attract attention as do the insane and criminal. It was therefore precessary to build an organization to find them and therefore necessary to build an organization to find them and

report on them.
"As there was little money to pay trained workers, Dr. Carlisle enlisted volunteers, largely among the professional classes in every part of the State, and, through these, found the people sought and collected data concerning their behavior, present history, school history, social relations (whether dependent, delinquent, or feeble-minded), the cause of their condition, and

so on.

"The prevention and correction of mental defectiveness," went on the Surgeon General, "is one of the great public health problems of today. It enters into many phases of our work and its influence continually crops out unexpectedly. For work and its influence continually crops out unexpectedly. For instance, recent studies made in connection with the spread of venereal diseases have shown that feeble-mindedness is an important factor in prostitution. Again, work of the U. S. Public Health Service in connection with juvenile courts shows that a marked proportion of juvenile delinquency is traceable to some degree of mental deficiency in the offender.

"For years Public Health Officials have concerned themselves only with the disorders of physical health; but now they are realzing the significance of mental health also. The work in Oregon constituted that first State-wide survey which even begins to disclose the enormous drain on a State caused by mental defects."

mental defects.

One of the objects of the work was to obtain for the people One of the objects of the work was to obtain for the people of Oregon an idea of the problem that confronted them and of the heavy annual loss, both economic and industrial, that it entailed. Another was to enable the legislature to devise a program that would stop much of the loss, restore health, and bring to lives of industrial usefulness many of those now down and out, and, above all, to save hundreds of children from growing up to lives of misery.

Tuberculosis Hospitals and Sanatoria.

Plans prepared by the U. S. Public Health Service and about to be put into effect will largely increase the hospital facilities for ex-service men in Pennsylvania, particularly at Pittsburgh and Philadelphia.

At Pittsburgh the capacity of the Marine Hospital (No. 15 will be trebled at first by the addition of a dozen portable buildings of approved type, and later, when Congress appropriates the necessary money, by new and permanent brick and tile construction. At present funds are available for the erection of portable temporary buildings only. The importance of Pittsburgh and the growing demand on the Government's hos-

Pittsburgh and the growing demand on the Government's hospital facilities there make these additions imperative.

At Philadelphia the U. S. Public Health Service has recently acquired from the Navy a large hospital for the care of ex-service men suffering from nervous and mental diseases. Its capacity is between 400 and 500. Recent heavy demands for accommodations by this type of patients have conclusively shown the need for this hospital, which it is hoped may become permanently devoted to its present use. may become permanently devoted to its present use.

New Laws Proposed in Oregon to Prevent Undesirable Unions.

New legislation is sought in Oregon to safeguard marriage. The press of the State reports the main features of a bill introduced by Senator Smith as follows:

"Any person desiring to obtain a marriage license from the county clerk must first undergo both a mental and physical examination at the hands of some regularly licensed physician. Should one or both of such applicants fail to pass the health and mental test, they shall not be permitted to marry unless both are rendered sterile."

The right to appeal to the county court is provided in case the order of the county clerk claims a failure to meet the requirements of the law. In case of such appeal a re-examination of the applicant is to be made by three physicians selected by the court.

by the court.

The health and sanitation committee of the legislature after expressing the belief that "a medical certificate, when required, should be of more than nominal value," proposed an amendment. This provides for "a Wassermann test for both male and female applicants for marriage licenses, and a fee of \$25

therefor.'

The Marriage Examination Law passed in 1913, and still in force, made no requirement for physical examination of the women contemplating marriage. It demanded from the man, however, a certificate from a duly authorized physician declaring his freedom from contagious or infectious venereal disease. The maximum fee for the physician making the examination is limited by the law to \$2.50.

A bill recently introduced by Senator George W. Joseph has for its object the repeal of the 1913 law, but public opinion in Oregon, according to press accounts, strongly favors a bill of some sort to protect marriage. The defects in the old law are admitted, says one paper, but it has a distinct educational value. In describing the law's defects and benefits the report says:

"Of course, there was much evasion. No physician for \$2.50,

"Of course, there was much evasion. No physician for \$2.50, unless of the extraordinary conscientious variety, could afford to make the thorough tests required for an examination of this kind. The result is that the custom has grown among most physicians of issuing the certificate only after a superficial examination. Also there have been unscrupulous practitioners who have issued these certificates without any examination whateverse.

who have issued these ceruncates without any whatsoever.

"Nevertheless in spite of these loopholes the effect of this requirement has been such as to force many men to arrange to be married across the State line. Portland men who were or had been infected or feared an examination, would take their prospective brides across the Columbia river to Vancouver, Washington. Similarly, Pendleton men who feared what an examination might disclose would take their prospective brides to Walla Walla, while southeastern Oregon contributed regularly to the marriage roster of Idaho county-seats, just across the Snake river.

"The extent to which this was carried resulted in building up with

"The extent to which this was carried resulted in building up a regular wedding industry in Vancouver, Washington, with signs out for the guidance of Portland couples who would go there in jitneys to procure the license and have the veremony performed. Often as high as half a dozen marriages of Portland couples would be licensed and ceremonialized at Vancouver in a single day.

"'Vancouver marriages' came to be a hy-word in Portland divorce courts and among the people generally. This comment has been taken by many to indicate that kind of a hasty and ill-advised marriage in which a man is willing to take a woman for his wife in spite of the fact that he knows himself to be affected with a venereal disease; also that the woman was so indifferent on such a serious matter that she would be willing to marry a man under those conditions. All these things combined have created enough talk since this law was enacted in 1013 so that the net result has been that men and women 1913 so that the net result has been that men and women enter the marriage relationship at least with their eyes open, instead of blindly, as they did prior to 1913 when there was nothing whatever to prevent any man actively and virulently affected from obtaining a license to wed a perfectly healthy woman."—(Social Hyg. Bull. March, 1921.)

Hindu Women Petition Against Prostitution.

A bill to deal with prostitution has been prepared for sub-mission to the Imperial Legislature of India by Dr. Tej Baha-dur Sapru of Allahabad. In support of this act a petition has been addressed to H. E. the Viceroy of India from the women of the country, more than 7,000 names having already been secured.

After citing the success attained in the United States and England toward eliminating commercial prostitution, those advocating the bill call attention to the great prevalence of the venereal diseases in India and their moral and physical result.

The text of the petition is:

"We, women of all classes resident in India, humbly pray for legislation which shall penalize commercialized vice, and make it illegal for a man to buy, and for a woman to sell womanhood for immoral purpose. We believe that such a law would result in abolishing the prostitute; in staying contagion from venereal diseases, in closing markets of vice, in shutting up disorderly houses; in destroying vested interest in immorality; in killing the traffic in women. Publicity and penalty would be deterrents to vice and a great gain to public health." Thousands of women are barred from signing because of their inability to write, but those who have been able to gain some education are reported to be enthusiastic in their approval of the proposed legislation. Printed appeals in English and in three of the Indian vernaculars are being distributed widely in Calcutta, Bombay, and other cities.—(Social Hyg. Bull., March, 1921.)

Bull., March, 1921.)

Sanitary Lapses

Not long ago a campaign against the common drinking cup swept the country and in an incredibly short time laws ordinances were passed in nearly all States and cities prohibiting the use of the common cup. No sanitary campaign has ever had such immediate and complete success as this one.

The common drinking cup was displaced largely by the drinking fountain. Various designs of such fountains were installed, usually without much study of the important question whether they would prevent the spread of infection. After installation they were frequently subject to neglect. The results may be seen in almost any tour of observation. Through faulty design interests installation less of receive a lack of free flow. sign, improper installation, lack of repairs, or lack of free of water, many fountains are a greater menace to health than the death distributing common cup.

the death distributing common cup.

The subject is one for sanitarians and health officers to deal with vigorously. Every day millions of people in industries, schools and public places drink from these fountains. Neglect in permitting improperly designed fountains to be installed, or defective ones to be continued, is a serious lapse from the high zeal which eliminated the common cup.—(Mod. Med., Sept., 1920.)

Organization of the Campaign Against Syphilis in France.

Organization of the Campaign Against Syphilis in France.

E. Leredde states that the figures which give the present annual mortality from syphilis are too low (40,000 for France; 60,000 for Germany). Syphilis is of all human scourges the most serious. Organization of anti-syphilitic campaign consists of two factors: (1) Educational, (2) the setting up of dispensaries for treatment, (a) to prevent the spread of all infection in such districts, (b) to attain the same end in other districts through the education of local doctors at the dispensary. Thinks that thirty million francs a year (300 dispensaries at 100,000 francs), will suffice in a limited number of years to wipe out social disease. Leredde emphasizes the importance of haying in charge of the clinic a general practitioner who has had additional training in venereal disease. intioner who has had additional training in venereal disease and who knows how to recognize diseases of nervous system, circulatory system, etc. The importance of the moral control of physician over patient is emphasized as the only way in which to secure perseverance in treatment; each patient should be seen by the same physician at each visit. The dispensary door should be wide open to every practitioner who is anxious to learn of the recent advances in syphilology. Every dispensary should be furnished with a serological laboratory.—(Internat. Jour. Public Health, January-February, 1921.)

Annual Report of the Chief Medical Officer of the Ministry of Health.

One portion of which deals with venereal diseases. "There are now 176 clinics for diagnoses and treatment, attendances in 1919 numbered 1,000,300 and there were 98,000 new patients of whom 42,000 suffered from syphilis. Roughly these figures are double those of the previous year."—(Public Health, 1919-

Measures Against Venereal Diseases.

Measures Against Venereal Diseases.

At a meeting of the Liverpool Medical Association, Dr. E. W. Hope spoke on "development of the scheme for the diagnosis and treatment of venereal disease in Liverpool." In 1919, 5,929 new cases, of whom 918 were females, were treated at the Liverpool Venereal Disease Clinics. In 1920 up to date with proportionate allowance till December 31, figures were—male new cases 5,476, with 1,071 females. The great disparity in the number of patients and of the different sexes, he stated was very significant. Some 60 per cent, of all cases discontinued treatment while still infective.—(Brit. Med. Jour., December 25, 1920.) cember 25, 1920.)

Venereal Disease in Transvaal School Children.

Venereal Disease in Transvaal School Children.
Opinion has been current that venereal infection among school children in the Transvaal was common. The experiences of C. L. Leitpoldt, Medical Inspector of Schools, do not corroborate this. He has gone over records of examination of school children since 1914, and found .06 per cent. of school children infected. At the end of 1919 had examined over 80,000 and found 45 cases. These figures lower than London, where author's 4 years inspection gave .2 per cent. Gonorrheal ophthalmia is rare in Transvaal. In school attended by half caste and native children author found .8 per cent. showed evidence of congenital syphilis; at another 3 per cent. at a third 1.8 per cent. For purely native schools the percentage works out just below .3 per cent.—(Med. Jour. South Africa, September, 1920.)

Causes of Blindness in Children in New South Wales, Since 1911, 71 children have been admitted to the New South Wales Institute for the Deaf, Dumb and Blind, 46 boys and 25 girls. Causes of blindness have been tabulated—ophthalmia neonatorum leads with 17 cases; syphilis 6. Gonorrheal infection thus accounts for 24 per cent. and gonorrhea and syphilis together for 32 per cent. — (Jour. of Australia, October 23,

Instructions for Midwives Concerning Ophthalmia

Neonatorum. By order of Board of Health all midwives in Austria must have acetate of silver and instil this into eyes of newborn baby. This is necessary because of the alarming increase of gonorrhea among lower classes.—(Vienna Correspondent, Lancet, November 27, 1920.

Frequency of Syphilitic Hemiplegia. With a view to determining the part played by syphilis, cases of hemiplegia occurring in a home for the aged in the period of hemiplegia occurring in a home for the aged in the period of hemiplegia. of October, 1919—February, 1920, were investigated. There were 84 cases, the ratio of syphilitic cases being 17.9 per cent.; of these, 15 cases the author comes to the conclusion, were directly due to syphilis, and in 10 the relation was uncertain.—(Vedsmand, Ugesrrift for Laeger, August 19, 1920.)

Notes on Venereal Diseases in the Army, Based on the

Study of 10,000 cases.

Table 1, analysis of the nine consolidated reports of individual venereal disease reports, numbers 1,000 to 10,000 submitted in complaince with S. G. O. circular letter No. 293, between September 10, 1919, and September 13, 1920. Table shows that percentage of gonorrhea is 65.83 per cent., of chancroid 21.15 per cent., and of syphilis 13.02 per cent. Pershows that percentage of gonorrhea is 65.83 per cent, of chancroid 21.15 per cent, and of syphilis 13.02 per cent. Percentage of soldiers infected who took prophylaxis after exposure is 46.9 per cent. (Captain Theodore Hall, Sanitary Corps, U. S. A., Military Surgeon, November, 1920.)

Note: These percentages are practically the same as those for some 8,000 cases in the British Navy in 1914, the last year for which statistics were available, which were, gonorrhea 68, chancroid 22, and syphilis 19.—(Lancet, January 8, 1921.)

Factors Making for a Low Venereal Record in the Army of the United States.

Colonel F. M. Ashburn, U. S. Army, has based his conclusions on replies to questionnaires sent to the men of thirty-seven of the largest camps. Replies were received from 14,444 white men. He believes that the low venereal rate is due to chestive of the men which is due invert the control of the record of the record of the men which is due inverted to the control of the record of the r seven of the lergest camps. Replies were received from Annumber white men. He believes that the low venereal rate is due to chastity of the men, which is due in part to greater activity of moral training and of anti-venereal teaching that has obtained in the Army since America entered the war, and to the official attitude in regard to it. The author, discussing prophylaxis, concludes that it is efficient enough to be used after any illicit intercourse, but it is not so efficient as to justify any man in counting upon use of it to compensate for lack of self-control.—(Military Surgeon, August, 1920.)

Results of Three Years' Treatment of Syphilitic Mothers and

Babies.

A table showing the result of treatment of women during pregnancy and of the newly born children at Thavies Inn Venereal Centre for Pregnant Women:

| Years Sept. 1- Aug. 1 | Mothers Admitted with Syphilis | Babies Born Alive Wassermann Reac. | | Babies Dying of Syphilis | Foetus Still-born from Syphilis |
|-----------------------------|---|---|------|-----------------------------------|--|
| 1917-1918 | 28 | Pos. | Neg. | 9 | |
| 1918-1919 | 30 | 8 | 21 | 1 | 1 |
| 1919-1920 | 37 | I | 36 | None | None |

The author, John Adams, concludes that a pregnant woman with syphilis, whether active or latent, if treated for three or four months before her confinement, will probably be delivered of a healthy child at full term.—(Lancet, November 13, 1920.)

The Physician's Library

Short Talks on Personal and Community Health. By Louis Lehrfeld, M.D., Philadelphia: F. A. Davis Co., 1921. Dr. Lehrfeld has presented in this book short talks on prac-

"Preventable Diseases and How to Avoid Them" and ending with a very few conservative remarks on "First Aid to the Injured."

Injured."

These talks are written very simply and without scientfic terminology, so that they may be understood by those with only a moderate education. They are quite interesting, and the meaning is readily understood. If the intimate knowledge of the subjects in this book could be demanded of every child in the upper grades of our grammar schools, a great deal would be accomplished in the way of preventive medicine.

Exophthalmic Goitre and its Non-Surgical Treatment.

By Israel Bram, M.D., St. Louis: C. V. Mosby Co., 1921.

In this book the author has given to the entire medical profession a great message. His plea is to determine the etiology of exophthalmic goitre and to treat it afterwards from this standpoint. He shows very clearly by case records and reports from reported authorities that treatment of such conditions as

from respected authorities that treatment of such conditions as gastro-intestinal disturbances, and disorders of the genital organs have produced cures.

He begins with the anatomy and physiology of the thyroid gland, then continues with the pathology and finally the pathogenesis of exophthalmic goitre. In his discussion of shell shock of soldiers he gives evidence of the fact that this condition is really one of Basedow's disease, produced by strain, anxiety and fear during the military career.

In the chapter devoted to treatment the author has gone into In the chapter devoted to treatment the author has gone into the subject very carefully and brings out the importance not only of systemic medication, but, also, of psychotherapy, diet, rest and even electrotherapy. He shows that all cases must be treated from the individual standpoint because "what is one man's meat is another man's poison." In his argument against surgery on the thyroid gland itself, he cites instances of recurrence after even two or three surgical procedures followed by complete medical cure. He, of course, agrees that surgery on other parts of the body that have an etiological bearing on the case is a rational procedure. Finally he quotes from Ochsner that those patients suffering from a recurrence of their the case is a rational procedure. Finally he quotes from Ochsner that those patients suffering from a recurrence of their symptoms after partial thyroidectomy had not followed instructions as to postoperative rest, diet and hygiene. These things are among the very important parts of Bram's treatment without surgery and for which he claims nearly one hundred per cent of cures with less morbidity.

His work is well written, with clearness of thought, and carries with it very definite ideas of how the author treats his patients.

Mr. Jensen's Book.

In our review of Mr. Albrecht Jensen's excellent book, "Masof the publisher. It has been published by Mr. Jensen, whose business address is Box 73, G. P. O., New York, and all communications regarding the book should be addressed to that post-office box.

Correspondence

Special Rules for State of New York Narcotic Drug Control. To the Editor of THE MEDICAL TIMES

To the Editor of The Medical Times:

Special Rules and Regulations for the City of Greater New York having been promulgated by me, taking effect June 25th, 1919, providing for the registration of all drug addicts in and for the City of Greater New York pursuant to the authority conferred upon me by Chapter 639 of the Public Health Law, Article 22, Section 421 thereof; and the necessity for such registration having been eliminated by regulation No. 12 of the new Rules and Regulations of this Department prohibiting the use of unofficial blanks by physicians issuing prescriptions for or administering or dispensing cocaine, opium or their derivatives and by regulation No. 16 requiring data concerning prescriptions for habitual users to be inserted on the official blanks. I, therefore, hereby revoke and repeal the aforesaid Special Rules and Regulations for the City of Greater New York requiring the registration of all drug addicts promulgated on June 25th, 1919, to take effect February 14th, 1921.

Walter R. Herrick, Commissioner.

The Value Static Currents.

To the Editor of THE MEDICAL TIMES:
In the current month's issue of THE MEDICAL TIMES there appears an article by Dr. P. Charles Green, of Philadelphia, under the caption "Do Doctors Advertise?"

While in the main the paper is a good one, and those parts that are correctly stated I approve, he does make some statements that are not correct, and as this is the case, I must not only disapprove of them, but protest in this public way in your columns

columns.

To quote: "If one goes into a doctor's waiting room and hears from his inner office a sound that is a cross between a stage storm and the blowing off of an exhaust pipe, there is no need to be rold that his static machine is at work. It makes a great impression, and not a thing is felt. Ideal combination. The machine in itself is big and impressive. The consensus of practical medical opinion is that outside of the psychic effect, it has little therapeutic value."

Any one who owns and employs a static machine scientificant.

sensus of practical medical opinion is that outside of the psychic effect, it has little therapeutic value."

Any one who owns and employs a static machine scientifically and properly for therapeutic purposes, knows that so far as the psychic effects are concerned, they are negligible. That the therapeutic action of the static currents has been amply proven, is well known to all who have their eyes and ears open to advanced scientific knowledge, but of course we cannot expect any one who has been asleep medically for the past twenty years to know this, so it will be of little use to try to prove this assertion under these circumstances. As far as the statement goes that "practical medical opinion" is concerned, it counts for nothing, if that same practical medical opinion does not keep up with medical progress.

If the gentleman who writes this learned (sic) paper will look up the records of the Surgeon General's office during the past great war, and take a peep at Fox Hills and other camps under the Surgeon General's department, perhaps his eyes and ears will be opened, if that is possible of accomplishment. Further, if he will read a report of one of the prominent physicists, not a medical man, Matthew Steel, Ph.D., of Long Island College Hospital, who made a series of experiments in their chemical laboratory as far back as 1916, and which has been published under the title "Influence of Electricity on Metabolism," he will have to admit that he is not yet out of the Rip Van Winkle sleep.

He also depreciates the value of the various lights, which have been so ably shown during the past war to be of utmost

Van Winkle sleep.

He also depreciates the value of the various lights, which have been so ably shown during the past war to be of utmost value, but of course no one expects this to be known to one who does not keep abreast of the times.

In the writer's mind the great thing to be deprecated is prejudice. When you add to this ignorance, you have a condition of mind that is deplorable. My only hope is that the author of that paper may live long enough to find out that the world still moves and that he will get his bearings for the future.

Late President of the American Electrotherapeutic Assoc.

Syphilis of the Heart and Aorta.

I. I. Lemann and A. Mattes studied the hearts and aortas of 100 consecutive autopsies, without regard to age or sex or race. The cause of death was manifold, absolutely no attempt being made to select cases. Number of aortas sectioned was 164. There were 55 that gave a microscopic picture of syphilis. Spirochetes were found in the aortas of two cases; there were

Spirochetes were found in the aortas of two cases; there were two aneurysm cases.

Observations:—the rarity with which a perfectly healthy adult aorta was seen; the large percentage (55) in which the histological findings corresponded with what has been set down as characteristics of syphilis of the aorta; the large proportion (27 out of 55) of the patients with changes in aorta; presumably syphilitic, who presented no evidence of cardio-vascular disease during life or so little of such obscure origin that it was not set down in the history.—(Southern Med. Jour., September, 1920.)

The Eye in Hereditary Syphilis.

A thorough study of the literature of the subject and a bibliography attached of "Further references" is given by John Green, Jr. The present study was undertaken to gain some conception of the extent to which the ordinar tissues participated in the lesions of inherited syphilis. "Analysis of eye findings in one hundred cases of hereditary syphilis: 74 of these children presented definite pathologic conditions in one or more of the ordinar tissues or some derangement of the ordinar function: a had fixed or unequal pupils: 4 had strabismus; 1 ptosis: ion; 9 had fixed or unequal pupils; 4 had strabismus; I ptosis; 3 nystagmus; 19 had had keratitis; 2 had fine haze in the vitreous; 52 showed pathologic eye-ground lesions.—(Amer. Jour. of Childrens Dis., July, 1920.)



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Suggestions for the regulation of infants' stools by slight changes in the make-up of the diet and particularly in relation to

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are given in our book, "Formulas for Infant Feeding," and in a pamphlet devoted especially to this subject. This literature will be sent to physicians who are interested in the matter.

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New York, the World's Teaching Centre.

At the annual meeting of the Association, held at the Academy of Medicine, March 7th, the by-laws were amended and the Board of Directors was reconstituted to apportion the con-The Lorentz of Directors was reconstituted to apportion the control of the Association's affairs to the five medical schools of Greater New York; namely, Columbia University, College of Physicians and Surgeons, Cornell University Medical College, the Long Island College Hospital, the New York Post-Graduate Medical School and Hospital, and the University and Bellevian College. vue Hospital Medical College.

This means that for the first time in the history of New York City the five medical schools will co-operate to develop New York City as a medical teaching center. Unnecessary duplication of courses of instruction by the several medical schools will be done away with. New courses and a higher type of graduate work will be instituted.

The new officers of the Association are:

President—Dr. Haven Emerson, formerly Health Commis-sioner of New York City, and at present in charge of the War Risk Bureau.

Risk Bureau.

Secretary—Dr. Otto V. Huffman, Associate Professor of Medicine at the New York Post-Graduate Medical School and Hospital, formerly Secretary of the State Board of Medical Examiners, and Secretary-Treasurer of the Federation of State Medical Boards of the United States, and formerly Dean of the Long Island College Hospital.

Treasurer—Dr. George W. Kosmak, Attending Surgeon of the Lying-in Hospital, and formerly Secreary and Editor of the American Association of Obstetricians.

The new Board of Directors is as follows:
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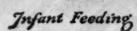
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Oxyl-Iodide.

A new derivative of phenylcinchoninic acid is offered by Eli Lilly & Company after more than two years of laboratory study and clinical test. It is called Oxyl-Iodide and is the hydriodide of phenylcinchoninic acid. It is said to exert the therapeutic action of phenylcinchoninic acid: an analgesic, antarthritic, antipyretic and uric acid eliminant-plus the alterative action of the

The use of phenylcinchoninic acid and its derivatives is comparatively new in medicine, but has gained steadily in favor. It reduces fever, relieves pain, and brings about elimination of waste products and general improvement in metabolism. In addition, it possesses the long-established virtues of the iodides, which more than doubles the worth of phenylcinchoninic acid. Oxyl-Iodide, we are told, has been used used with success in

Oxyl-Iodide, we are told, has been used used with success in brachial, intercostal and sciatic neuritis, in lumbago and other types of muscular rheumatism. Even such difficult and hopeless cases as arthritis deformans have been benefited by relief from pain and increased mobility of stiffened joints after thorough treatment with this product. Types of chronic arthritis are said to have responded with steady improvement, and in some instances were apparently cured. Oxyl-Iodide has been used also in acute and sub-acute bronchitis where it was given on account of persistent bronchial irritation and cough with tenacious mucous expectoration. In one case of diabetes, Oxyl-Iodide was given on account of recurrent attacks of circumflex neuritis. Not only was relief said to have been obtained from nerve pains, but urine sugar was greatly decreased. Given in traumatic orchitis, pain was relieved, we are told, and rapid absorption was promoted. In eczema, of papulovesicular type, Oxyl-Iodide gave marked improvement. In other conditions, in some of which there was perhaps a luctic basis to confuse diagnosis and resist ordinary measures of treatment, Oxyl-Iodide was given with marked benefit.

The above statements, according to Eli Lilly & Company, are based on conservative.

The above statements, according to Eli Lilly & Company, are based on conservative case reports. They seem to suggest other indications for the use of Oxyl-Iodide. Physicians will

other indications for the use of Oxyl-lodide. Physicians will no doubt see the rationality in its use in many other conditions. The analgesic action of Oxyl-lodide is said to be gradual. There is a stimulation of the endocrines which is perhaps more marked in the thyroid gland, although it is probably shared by the pituitary and other glands which function in a chain-like

Whatever the cause of rheumatism, be it focal infection from teeth, tonsils, gall bladder, kidneys, abdominal pus sacs, colitis, or dietary and metabolic disturbances due to excessive eating, improperly balanced diet or imperfect digestion, Oxyl-Iodide will aid, it is thought, in restoring normal conditions.

Given in proper dosage, Oxyl-Iodide, it is said, does not tend to cause gastric irritation.

Further information concerning this interesting product will

Further information concerning this interesting product will supplied by Eli Lilly & Company on requests addressed to Indianapolis

The drug trade supplies Oxyl-Iodide in bottles of 40 threegrain tablets

Results Speak Louder Than Theory.

Results Speak Louder Than Theory.

When one finds that under certain treatment the blood pressure of one patient or another is reduced 30, 50 or more millimetres withn a short period, eventually coming down to normal (for the case in hand) and remaining there, this diagnosis is not arrived at by "dead reckoning," but is substantiated by an instrument of precision, the sphygmomanometer; there is no guesswork about it. So when innumerable physicians report that by means of Dr. M. C. Thrushs formula they are able to reduce hypertension and control it, we must believe them. Thus one of the leading heart specialists in New York states that Pulvoids Natrium Compound will quickly and safely bring about the reduction of high blood pressure and keep the patient in a safe condition until the underlying factor can itself be controlled by indicated treatment. The Drug Products Co., Inc., whose advertisement appears in this issue, offer to furnish convincing proof of the efficiency of this treatment.

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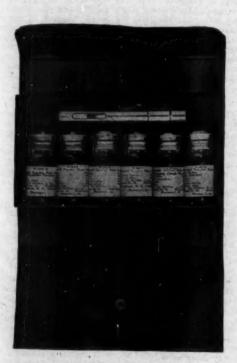
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-and the malodorous dejecta of typhoid and other intestinal cases come under the same category-

can be made materially less prejudicial to the nurse's health if you permit her to insert a tuft of "Nazeptic Wool" in each nostril before she dresses the cancer or empties the used vessel. "Nazeptic Wool" is absorbent cotton medicated with phenol, eucalyptol, methyl-salicylate and menthol; such odors, when filtered through the "Wool" during inhalation, are materially antisepticized. Samples are available.

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upon nervous exhaustion.

It is formally indicated in the præ-tuberculous period, in confirmed phthisis, in rickets, anorexia, in malarial, cancerous and other cachexiæ, in delayed convalescence, and after labour and hæmorrhage, in fact in all cases of deficiency of red corpuscles and physiological misery, of whatever origin.

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all the physical, chemical and biological properties of the hamo-globin of the blood itself."

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Pulsatilla Useful in Melancholia

In all cases where the patient complains of fear of impending danger, something is sure going to happen to her, or to him, dysphagia, a general unrest with a tendency to look on the dark side of life, give pulsatilla.—(Therapeutic Digest.)

The Modern View of Thyroid Disorder.

The thyroid glands produce and discharge into the blood and lymph a complex secretion which contains, in case of normal metabolism, the exact amount of active principle or hormone required to maintain a normal condition. This substance influences certain tissues directly and affects many functions of various organs. This action is performed through humoral channels and is accredited to the hormone contents. These hormones are essential to life, a fact which explains the danger involved in extirpation of thyroid glands. Imperfect development, or disease of the thyroid caused by disturbed metabolism, malnutrition, unfavorable climate, or altitude, impure water, etc., are a great menace to health and life. Cretinism, and myxedema are both associated with a deficiency of the thyroid secretions. A similar condition is produced by the surgical removal of the thyroid gland.—(Therapeutic Digest.) of various organs. This action is performed through humoral

Chancre of the Tonsil.

Whereas in Fournier's statistics only 69 or 6.13 per cent. of 1,124 extragenital chancres were situated on the tonsils, as compared with 75 lingual and 567 labial chancres, in more recent statistics the tonsil is the commonest site for extragenital chancres; thus Brobie in 1914, out of 324 extragenital chancres in women found 97 or 29.7 per cent. situated on the tonsils, 57 on the upper lip and 45 on the lower lip. Writer reports two unusual cases.—(Rev. de laryng., d'otol. et de rhinol., September 30, 1920.) tember 30, 1920.)

The Art of the Therapeutist.

The Art of the Therapeutist.

It is pleasant to think of therapeutics as an art rather than as a cold science. The thought suggests the mature artist who through the medium of a few well-chosen tints, is capable of giving expression to his fancy or his emotions.

To the ingenuity of the artist may be likened that of the therapeutist who selects his agents with consummate skill. He applies them deftly, here and there, as the artist touches the canvass with his pencil, with results that are definite because, he has in mind a definite plan of procedure. Even the selection of a simple laxative—Pill Alophen, for example—is not a haphazard act, but entails the exercise of judgment and skill based upon experience and a comprehensive knowledge of physiology and therapeutics.

hased upon experience and a comprehensive knowledge of physiology and therapeutics.

The physician skilled in his art clearly sees certain indications for Pill Alophen—the necessity of relieving an overdstended colon with the least possible disturbance of a delicate organism, perhaps. He mentally reviews the list of available laxatives, to most of which there is some contra-indication—they do not exactly suit the conditions; they do not blend into the therapeutic scheme, so to speak. But Pill Alophen presents no such objection. Its action is mild, gentle, yet thoroughly efficient. Its administration offers no difficulty—it is beautifully coated with sweetened chocolate. But one pellet is sufficient in most cases, preferably taken at bedtime, and the result is all that one could wish—an easy, complete evacuation in the most natural way imaginable.

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Impacted Ear Wax.

It is a well-known fact that many cases of progressive deafness are in reality simply an accumulation of wax, with the dust and other material that naturally lodges in the ear and works its way back into the canal. This accumulated wax and débris tends to harden, and in time will often entirely seal up the external passage. The hearing is markedly impaired and may seem to be almost completely lost. If the hardened mass impinges against the drum it very frequently will cause ulceration and even perforation of the membrane.

Various measures have been used with greater or less success in removing impacted serumen, but of all the procedures that have been employed none has proven more effective than

cess in removing impacted serumen, but of all the procedures that have been employed none has proven more effective than the instillation of Dioxogen. A simple and dependable method is to dilute a small portion with an equal part of warm water. Then, while patient tips head to opposite side instil by means of a medicine dropper about ten drops of this Dioxogen deep into the canal of affected ear or ears. A pledget of cotton well wet with the same strength solution of Dioxogen, should then be inserted into the canals, and left ten to twenty minutes. At the end of this period, these pledgets should be removed, and the external canals syringed with a solution of Dioxogen—

one part to five of warm water. Usually a few syringefuls will suffice to bring away the softened and detached plug which has been occluding the canal. If they do not, persistence in syringing will rarely fail sooner or later to accomplish this re-

syringing will rarely fail sooner or later to accomplish this result. Should the ear plug be too hard and adherent to come away readily, it may be necessary to instil the 50 per cent. solution of Dioxogen again for another ten to twenty minutes. After this, the plug will be removed with ease, and simple as it is, there are few of the many services which medical men render, that will usually be so spectacular, or gratifying in immediate effects, as this removal of impacted wax by Diox-

Tife purity of Dioxogen, its freedom from irritating proper-ties, and its pronounced effect on impacted wax, makes it the safest, as well as the most potent measure at the physician's command for relieving this disagreeable condition.

The Mead Johnson Policy.

Mead's Dextri-Maltose is advertised only to the medical profession. No feeding directions accompany trade packages. Information regarding its use reaches the mother only by written instructions from her doctor on his own prescription blank.



Prohibition ONE of its Responsibilities for the General Practitioner

Prohibition, no matter what its results in social progress and economic advancement, has precipitated a responsibility upon the medical profession, the burden of which is being borne by the general practitioner. Reference is made here to the intensification of narcotism in society generally and in individuals specifically.

Case records here show particularly an increase in the use of opium derivatives—this perhaps because of the ease with which they can be obtained through illegal channels.

While it is true that certain types of narcotic patients must be continued indefinitely under medical sanction—such as chronic sufferers advanced in age, those having persistent functional disturbances, inoperable organic states—nevertheless, the great majority are eligible for definite clinical measures which have as their object the removal of accumulated toxins, and the subsequent clearing up of attendant complications.

Records of patients so treated at this Hospital show results of interest to practitioners in general. These results are: (1) Elimination of toxins from the body tissus. (2) Loss of craving for the accustomed drug. (3) The bringing to light of underlying systemic troubles. (4) The opportunity for considering the patient as a sick person rather than as an habitué.

With the patient relieved of the underlying toxemia of narcotism, it is but natural that any obscured under-

lying condition should be disclosed. Such disclosure affords the physician positive grounds for determining his future course with the patient, be it an operation, medication, hygienic measures, or as sometimes happens, continuance of narcotic administration.

At this time, therefore, attention is called to the facilities of this Hospital for aiding physicians with their narcotic patients. The profession is invited to make use of its services in determining intelligently the physical, moral and legal status of such patients, and the responsibility to these patients in a professional way.

The interest of the Hospital is primarily in assisting the practitioner to a demonstration of his patient's independence of narcotics, although in some cases it may demonstrate the patient's need of the drug for the alleviation of irremediable suffering. In either class of patients, however, the craving, the habit factor is eliminated and responsibility for renewal of the drug intelligently determined.

The Hospital invites correspondence with physicians whether or not their patients shall be referred here for treatment. Literature sent on request.

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Early Spring Type

Patients whose hay fever develops in late March, April, or beginning of May, should be tested with pollens of early flowering trees.

Late Spring Type

Patients whose hay fever develops in the latter part of May or during June should be tested with the pollens of the chief grasses, such as orchard grass, timothy, red top-and certain early flowering weeds.

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For Cutaneous Tests and Treatment cover early and late spring, also summer and autumn.

Literature and List of Pollens on Request

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Genesis of Round Ulcer.

Ulcus pepticum ventriculi sive duodeni can be the result of a neurosis of the vegetative nervous system which through psychic emotional factors can lead to an endotoxic herpetic neuritis in the mesenteric plexus. Such ulcers which tend to be very chronic and, in the constitutionally disposed, either from the neurosis or external factor, set up a vicious circle resulting in chronic gastric and duodenal ulcer.—Jour. Nerv & Ment. Fis.)

This is, perhaps, an opportune moment to sound a note of warning lest we become blind to the limitations of organizing investigative effort. It is likewise a favorable time for uttering a plea for the individual worker in science. He muust be encouraged, not merely permitted, to unfold his own personality—his own point of view and perhaps even his seming eccentricities of mind. He must be permitted, at all events, to preserve the open mind rather than to be biased by the projects of a company of scholars. A league of investigators might promote lasting benefits to the world. No one wor'expect it to make a scientific discovery. Let us by all means facilitate the progress of science by furnishing the requisites for research by organized effort to promote the aims and storth results, by systematic planning and co-operation which will make established facts easily available and widely known. Let us increase the number and variety of national or even international institutes if there is prospect of intellectual, social or economic gain thereby. But amid this growth of the gettogether spirit and better intellectual community let us always bear in mind the individual who, does the thinking. We need not be blind to the need of integration in science; we must not be forgetful of the man. Genius is found in men, not in organizations.—(J. A. M., A.) This is, perhaps, an opportune moment to sound a note of

Discernment of Intrathoracic Neoplasms by Aid of Diagnostic Pneumothorax.

Diagnostic pneumothorax is resorted to by Maurice Fishberg, New York, for the purpose of discerning intrathoracic neoplasms along the lines of pneumoperitoneum. This method was suggested by Brauer in 1912 and attempted by Schroeder in 1916. With this method, Fishberg has been able to show the tumors clearly. He pleads for a wider use of this procedure, which, it is claimed, is harmless, except perhaps in cases of aneurysm.—(J. A. M. A.)

Alkalol as a Spray.

So far, the prophecy that the present winter season would mark a return of the flu epidemic seems to have been unfulmark a return of the flu epidemic seems to have been unful-filled. There are, it is true, numerous sporadic cases which seem to resemble those which were so common last year. It is a rather interesting thought, as expressed by a promi-nent medical man, that perhaps the present dearth of grippe cases may be due in part to the efforts of the laity to carry out suggestions made to them regarding the ade-quate and proper disinfection of the mouth and of the nasal passages. It is not an uncommon occurrence to hear a to carry out suggestions made to them regarding the adequate and proper disinfection of the mouth and of the nasal passages. It is not an uncommon occurrence to hear a patient express the belief that since the use of Alkalol as a nasal spray, mouth wash or gargle was begun, there has been a remarkable freedom from colds and even ordinary nasal irritation. Alkalol is, beyond doubt, a preventive. It has been laid down as an axiom that the most effective antiseptic solution that can be used upon any mucous membrane is the normal secretion of its cells. Alkalol is based upon the sound therapeutic idea of feeding depleted or exhausted mucous membrane cells and thereby restoring them to normal secretory activity. So that Aikalol does good not only on account of its soothing and healing properties, but because it feeds the cells and thus enables them to recover normal tone. The steadily increasing use of Alkalol is explained by these facts and it is certainly well worth while for every physician to become personally acquainted with the product. This is easily accomplished because the Alkalol Company of Taunton, Mass., will be glad to send a sample and interesting literautre regarding Alkalol to any physician on request.

The Case of Anne Boleyn.

This is an historical article written to prove that Henry VIII. This is an historical article written to prove that Henry VIII had syphilis. About the time when he was a young man, this disease, which had been introduced by Columbus' men, ran through Europe. This would explain the still-births of children of Catherine of Aragon. Her only daughter, Queen Mary, shows from her portraits that she was an hereditary syphilitic. Anne Boleyn also had miscarriages. She was suffering with nymphomania, and, according to the author, should have been in an insane asylum. After Elizabeth was born Henry developed an intractable ulcer on the thigh, also had terrible headaches due to high blood pressure.—(Med. Jour. of Australia, October 30, 1920.)

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Aleukemic Leukemia With Unusual Skin Manifestations.

In the case reported by M. A. Blankenhorn and Harry Goldblatt, Cleveland, the entire surface of the body, including the scalp, the soles and the palms, was covered with lesions of various kinds and shapes, ranging from miliary points to patches more than 5 cm. in diameter. The majority of them were purple, hemorrhagic in appearance, and slightly elevated, thick and firm. Some of the lesions showed only extreme reddening, while in others there was a purple that had faded to a brown. Some of them were desquamated with a brown, dry scale, while others had superficial layers elevated by a sticky layer of creamy pus. None were deeply ulcerated, and all showed varying stages and degrees of infiltration and hemorrhage. In particustages and degrees or infiltration and hemorrhage. In particular, no single lesion could be said to be a simple purpura unaccompanied by infiltration. The membranes of the mouth and conjunctiva showed the same lesions, but here superficial ulceration, complicated by secondary infection and encrusting, was more marked.— $(J.\ A.\ M.\ A.)$

Treatment of Aortic Aneurysm by Wiring and Electrolysis.

Three cases of sacculated aneurysm of the aorta successfully treated by wiring and electrolysis are reported by Hobart Amory Hare, Philadelphia. He emphasizes that one of the most important effects of the operation is the relief of pain, which usually occurs almost at once in every case.—(J. A. M. A.)

Retinitis of Diabetes Mellitus.

In a course of a statistical study of the clinical types of diabetes mellitus encountered in the Mayo Clinic, it was ob-served that retinal lesions had been found only in patients with served that retinal lesions had been found only in patients with the mild form of diabetes, usually associated with arteriosclerosis. This observation led to a more careful examination by H. P. Wagener and R. M. Wilder, Rochester, Minn., of diabetic patients for retinal lesions. In about eighty cases of diabetes characterized by acute onset and progressively increased severity, the so-called diabetes gravis, no patient showed retinal changes. Retinitis occurred exclusively in diabetic patients with mild, easily controlled glycosuria in whom evidence of vascular disease was always present. At least twice the authors were able to make a diagnosis from the ophthalmoscopic findings alone in the temporary absence of sugar from the urine. They believe, therefore, that the retinitis of dia-

betes is the retinitis of cardio-vascular-renal disease, modified in appearance and in stage of occurrence, possibly by the meta-bolic disturbances associated with the diabetes.—(J. A. M. A.)

Intracranial Pressure in Disease.

The intrancanal pressure was determined by Charles E. Kiely, Cincinnati, in thirty-one cases. It varied from 25 in a case of taboparesis to 400+ in a case of syphilitic myelitis. In two cases of tumor the pressure was 136 and 160, respectively. Kiely uses an O'Brien needle to which a by-pass is added.—(I. A. M. A.)

News Item.

The Minnesota State Board of Health announces that dur-The Minnesota State Board of Health announces that during October two druggists were successfully prosecuted in St. Paul for selling venereal disease remedies without prescription; each was fined \$10 and costs. In November a physician was prosecuted in Minneapolis for failure to report cases of venereal disease treated by him, and was fined \$20 and costs. In December another physician was prosecuted in Minneapolis on the same charge and was fined \$50 and costs.—(Medical News Journal A. M. A., January 1, 1921.)

The Wasserman Test and its Limitations in Diagnosis and Treatment.

Treatment.

This paper by G. L. Rohdenburg, A. L. Garbat, Leo Spiegel and P. J. Manheims, covers experience in 48,000 tests. Reviews the three influencing factors: the patient, the collection of the specimen, alterations in technique. In the study of 1,200 cases of clinically definite syphilis, two types of variations become evident which can not be explained by any of the above factors: (1) 46 of the old syphilities in one series gave negative tests of which he became positive during or after treatment; (2) another type of unexplained fluctuation (also encountered by other workers) consists of sudden changes from negative to positive or vice versa with no relation whatever to treatment. In 3,165 tests on known syphilities these sudden changes occurred 108 times. From cases in which tests were carried on over a series of years authors deduce that the correct method of treatment is one that is intensive at the outset.—(I. A. M. A., January 1, 1920.) 1920.)

Gastric Analysis.

Matin E. Rehfuss and Philip B. Hawk, Philadelphia, stress the point that gastric analysis has three important functions:

(a) the determination of evacuation time or motor activity;

(b) the determination of secretory activity and work, and (c) the presence of pathologic products which offer a clue to the type of disease present. Evidence is offered to show the marked variations of evacuation in health, and the same thing is true of the secretory variations. The author's studies have emphasized the minor importance of high acidities and the increased importance of low acidities in disease. Standardization of test importance of low acidities in disease. Standardization of test meals is absolutely essential to a satisfactory understanding and interpretation of variation in health and disease. There is ab-solutely no value in complexity of test meals, which only insolutely no value in complexity of test means, which only introduces confusion to a subject already sufficiently complex. It is essential to realize the normal sequence of the digestive and interdigestive or rest phases, in order that the variations which occur in disease may be detected.—(J. A. M. A.)

Indirect Expulsion of the Placenta.

In 1919, Joseph L. Baer, Chicago, in *The Journal*, May 24, page 1543, described a method of expelling the placenta which is a reversion to Nature's spontaneous method, utilizing the full power of the abdominal muscles to drive the uterus down against the separated placenta and so expel it. The method is applicable only after separation has occurred, but even if used as a routine in all cases because of inability to recognize separation in the followed by as a routine in an cases because of mainty to recognize separation, its failure is harmless and can always be followed by a simple expression or a "Credé" as the case may require. An analysis of 400 consecutive cases by the same author shows that the method is 90 per cent. efficient in the hands of seventeen men of limited experience.—(I. A. M. A.)

Perforations of Nasal Septum Due ot Inhalation of Arsenous Oxid.

Arsenous Oxid.

L. G. Dunlap, Anaconda, Mont., differs with Rothstein as to the theory that the perforations sustained by workers with arsenic are due to primary injury of the Kiesselbach area by the finger-nail in picking the nose, as occurs in tabetics. He is convinced that the inhalation of arsenous oxid and hydration to arsenous acid on this area of least resistance of the septal mucosa cause a tissue necrosis and defense reaction of hyperemia. Obstruction follows. This leads to vigorous blowing of the nose, all of which factors form the basis of the original abrasion. Treatment consists of: (a) resection of cartilage, producing mucosa to mucosa approximation, or, in smaller perforations, (b) plastic operation, or (c) a mechanical obturator to relieve the objectionable crusting.—(J. A. M. A.)

Angina Pectoris of Diabetes.

The belief is held by Max Kahn, New York, that clinicians have not been impressed with the cardiovascular changes that are present in diabetes. He directs attention to angina pectoris, which is especially overlooked. A patient with normal or low blood pressure frequently complains principally of attacks of angina pectoris. These anginal attacks do not seem to occur when the patient's glucose tolerance is not exceeded. A high blood sugar with glycosuria in such an individual will frequently cause the recurrence of the attack. It appears that A high blood sugar with glycosuria in such an individual will frequently cause the recurrence of the attack. It appears that the carbohydrate storage in parts of the heart has something to do with cardiac conductivity. It has been found that the fibers of the bundle of His are markedly richer in glycogen granules than the ordinary cardiac muscle fibers. It is logical to assume that in the condition of diabetes there is a lowering of the glycogen storage here as elsewhere in the body, with a resultant distinct disturbance in the nourishment of the cardiac musculature, terminating in myocardial pathologic changes. Cardiographically, a number of the diabetic patients suffering with this condition will show an inversion of the T wave in the third lead.—(J. A. M. A.)

Splenomegaly With Multiple Abscesses of Liver.

Splenomegaly With Multiple Abscesses of Liver.

The case reported by J. Morrison Hutcheson, Richmond, Va., exemplifies an unusual degree of splenomegaly occurring in the course of a severe infectious disease and also in the presence of profound hepatic disturbance. The case is of interest in that it shows an unusual combination of clinical and pathologic fiindings, probably arising as a result of an acute cholangeitis. Cholecystectomy for calculus had been performed four years before, and exploration of the common duct eighteen months prior to the admission to the hospital. There had been intermittent attacks of abdominal pain, with chills and fever and almost constant jaundice, for four years. There was rapid enlargement of the liver and spleen, with ascites and clubbing of the fingers. Abdominal fluid was removed by tapping about every ten days. Roentgen-ray examination indicated a mod-

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erate amount of fluid in the right lower chest with displacement of the heart to the left. The patient died. A necropsy was performed. The liver weighed 2,394 gm. and contained numerous abscesses filled with greenish pus and varying in size from microscopic to the size of a hen's egg. The upper surface showed two openings through which abscesses had ruptured through the diaphragm into the right lung. The ducts were patent and no stones were found. The spleen weighed 1,888 gm., and was smooth and rather soft. No gorss or microscopic abscesses were found, and no evidence of thrombosis.—(J. A. M. A.) M. A.)

Juvenile Tabes.

Juvenile Tabes.

The literature on juvenile tabes is reviewed and summarized by Charles Rosenheck, New York, and one case is reported. He is convinced that juvenile tabes may be considered a distinct clinical entity. Apparently it is the result of an hereditary syphilitic infection in the great majority of cases. An insignificant number of cases are due to syphilis acquired during infancy. Its symptomatology differs in no way from that of the adult type, but special characteristics in its onset and course are worthy of note. Early visual difficulties proceeding to blindness and optic atrophy are characteristic of fully 40 per cent. of the cases. Lancinating pains, ataxia, and visceral or vesical disturbances affect only a small number. Trophic disorders are absent. Females are particularly vulnerable to the affection; as twice as many girls show the disease as boys. The ratio in the adult type is placed as ten men to one woman (Gowers). The prognosis is excellent for life, but extremely poor for vision.—(J. A. M. A.)

An Experimental Study of the Latent Syphilitic as a Carrier.

An Experimental Study of the Latent Syphilitic as a Carrier. Frederick Eberson and Martin F. Engman concludes:

"It appears from this investigation, and that of others, that any other body fluids, excepting semen, are not infectious in latent syphilis, or if so only rarely." The groups of patients studied were composed of those that were untreated as well as those that had received no treatmnt within the last two years. Between time of taking specimens, and the first symptoms of a suggestive history of syphilis in the patients, from one to forty years had elapsed. In this study spirochaeta pallida has been isolated in five instances from latent syphilities, three times from inguinal glands, twice from the semen.—(J. A. M. A., January 15, 1921.) 1921).

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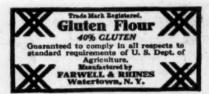
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Last Foreign Quarantine Station Goes to Public Health Service.

With the transfer, now imminent, of the New York Quarantine station to the U. S. Public Health Service, the Federal government has come into complete possession and administrative control of the country's inner line of defense against disease coming from abroad.

disease coming from abroad.

Legislation, first adopted in 1893 and subsequently supplemented, provided for the purchase by the Federal Government of the seaport quarantine stations of such States as might be willing to part with them. Most States were glad to be relieved of the expense of carrying on a work that was essentially one for national rather than local protection; but some of them hesitated to give up local control, especially in the early days when ideas of proper quarantine methods differed radically, owing to the lack of information now available as to the transmission of the great plague diseases.

However, one by one the stations were taken over until only New York was left; and now by the payment of nearly two millions the Federal government has taken over the station.

Public Health Service Forced to Transfer Tuberculosis Patients to the East.

All the hospitals and contract hospitals of the U. S. Public Health Servee in the semi-arid Southwest are already crowded with tuberculosis patients and the influx of others from the Eastern States continues so great that the Public Health Service has been forced to transfer patients from Tucson, Ariz, and other Western hospitals to sanatoriums near Asheville, N. C., and elsewhere in the East.

Many ill-advised patients have of late thronged to Tucson, unmindful of the fact that every hospital bed in that place is filled and every hotel and boarding house overcrowded. More than 500 tuberculosis subjects in Tucson are unable to find entrance to a sanatorium. Other towns in the Southwest report similar conditions.

similar conditions. Surgeon General Cumming again renews his warning against tuberculosis patients leaving sections where the government is able and willing to care for them and going to the Southwest on their own mitiative.